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Series V Volume XIII No. 3 SEPTEMBER 1991

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Editorial

On 17–18 May 1991 the Francis C. Wood Institute for the History of Medicine of the College of Physicians of Philadelphia convened a conference on an issue of national significance for contemporary health care in America. The conference titled "Seeking Common Ground: Law, Medicine, and Patient Care in the 1990s" had a special and original character. Its focus was the important one of the resolution of doctor-patient conflicts. It was conceived though not in terms of discussion amongst just one or other of the groups drawn into these disputes but as a forum for all to present their views. Thus, physicians, lawyers, insurance executives, patient care advocates, legislators, judges, historians, health care policy makers, and health economists had the opportunity to talk directly to each other about their perceptions of malpractice issues. All those participating agreed on the value of co-operative interaction rather than adversarial reaction as a way to diminish tensions and solve problems. To pursue such an agenda, this issue of *Transactions & Studies of the College of Physicians of Philadelphia* has been devoted to the conference. Publication of the talks and the panel discussion will enable readers from a broad range of backgrounds to benefit from the insights brought forth by the conference and be stimulated to further initiatives to ensure the well-being of the patient and all those who provide care in America's health system.

A conference of this scope and the publication of a special issue of *Transactions & Studies* does not take place without the generous assistance of many people and institutions. The Wood Institute especially wishes to thank the following sponsors for their splendid support of our initiative: Bernstein, Bernstein & Harrison; Delaware Valley Ethics Committee Network; Duane, Morris & Heckscher; The Groff Family Memorial Trust; Independence Blue Cross; Benjamin and Mary Siddons Measey Foundation; The William Penn Foundation; Pennsylvania Humanities Council; Pennsylvania Medical Society Liability Insurance Company; PHICO Insurance Company; Post and Schell; and The Winchell Company.

Particular recognition and thanks must also be given to a number of individuals. The expertise, organizational abilities, and energy of Janet Tighe, the project co-ordinator, made the conference happen. Her informed knowledge has made the co-editorship of this issue a pleasure and netted our readers the benefit of a valuable

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introduction. Julie Johnson, a historian in the making, has worked capably and diligently as project assistant in administrative and research capacities, and Carla C. Jacobs has provided deft support not only in planning and running the conference but also in dealing with all the difficult managerial aspects of editing this number of *Transactions & Studies*.

Nancy Tomes, one of the originators of this project, deserves grateful thanks for her continuing commitment to and encouragement of the enterprise as well as her contribution in ably chairing the morning session. Michael Kemler offered expert opinion as legal consultant for the law and medicine program. His perspective and eye for the issues proved invaluable and his contribution to the discussion stimulating. William Kissick offered his assistance in several ways. Not only did he help plan but he acted as a resource person throughout and was gracious enough to wrap the conference up. Rosemary Stevens was a real friend to the project.

At the College of Physicians of Philadelphia, Andrea Kenyon and Tracy Byrd guided and assisted us in the task of a multi-disciplinary research endeavor. L. Cathryne Foedisch and Jerry Condon gave us the benefit of their considerable knowledge and experience in the fields of public relations and fundraising and John M. O'Donnell provided his executive office support. Maggie Devine and her staff in the office of Special Events and Hall and Grounds gave much needed practical assistance. Finally, we would like to thank Daniel L. Shaw, President of the College of Physicians of Philadelphia, and Robert H. Bradley, President-elect, for their personal interest in this Wood Institute project.

CAROLINE HANNAWAY

Special Issue on Law, Medicine, and Patient Care in the 1990s

Introduction

JANET A. TIGHE

Few problems besetting the embattled American health care system have been more troubling to both medical personnel and their patients than the growing sense that the therapeutic relationship has become an essentially adversarial one. The once strong trust existing between physicians and patients has eroded and for many has been replaced by a much more antagonistic mentality. The tension engendered by this profound loss of faith in the therapeutic alliance has created an atmosphere in which disputes over medical care have become increasingly common. Third parties — lawyers, judges, hospital administrators, insurance companies, and the like — have been enlisted as important agents in the resolution of these conflicts.

Over the past 30 years, the resolution of conflicts over patient care has become increasingly costly to the American public, in both psychological and monetary terms. The most visible of these costs are related to the increase in medical malpractice lawsuits. They include the rising cost of malpractice insurance, which is passed on to patients in the form of higher fees and insurance premiums; the increasing practice of "defensive" medicine, in the hopes that ordering expensive laboratory tests will avoid malpractice suits; the decline in the number of specialists such as obstetricians and nurse midwives, because of prohibitively high malpractice insurance rates; and the overloading of the legal system with medical care-related litigation.

While many publications and conferences have been devoted to specific issues such as rising malpractice insurance rates, defensive medical tactics, and informed consent, our program had two unique features that enhanced its ability to stimulate creative and constructive thinking about the resolution of patient care conflicts. First, our program stressed a broad, multidimensional analysis of the problem. For the most part, the existing literature on doctor-patient conflicts is extraordinarily technical and written with only an audience of specialists in mind. There is very little consideration of the

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historical developments that have shaped the debates over such seemingly disparate topics as malpractice and informed consent. To counteract the usual limited approach to these topics, we chose speakers capable of illuminating the underlying changes in the practice of medicine and the larger society that have contributed to the current crisis. By emphasizing these social forces, we hoped to move participants beyond the current system, which tends to promote piecemeal, inefficient solutions, and encourage the quest for policy alternatives that will benefit the whole society.

The second unique feature of our program is its attempt to bring together leaders from *all* of the groups involved in patient care conflicts in a neutral, non-adversarial setting. Much to our surprise, when we first began investigating previous conferences on related topics, we were told that the idea of bringing doctors, lawyers, insurance executives, risk managers, judges, and legislators together to discuss these issues represented a real innovation. Policy discussions usually take place within specific professional groups and seek solutions, usually limited and technical in scope, for discrete problems. By bringing professional leaders from differing backgrounds together to consider their common problems and interests we hoped to foster a broader, more creative approach.

The "Seeking Common Ground: Law, Medicine, and Patient Care in the 1990s" conference that inspired this volume was convened for this purpose. The participants in the conference were offered the rare opportunity of speaking directly to a wide variety of influential individuals who share their concern with, but not always their approach to, the current "crisis" of medical authority. The audience for this conference included a spectrum of community and professional leaders from the Philadelphia area. In attendance were representatives from the local medical and legal associations, the judiciary, the legislature, insurance companies, medical and law schools, local hospitals and universities, as well as practicing physicians and attorneys concerned with health care and malpractice issues. Participants were asked to take a fresh look at the current crisis of medical authority. They responded by recasting the issues involved in medical-legal disputes and looking at them not so much as a product of conflict among *doctors, patients, and lawyers,* but of larger changes in society that have affected a wide variety of professional groups and the public.

As the essays which follow demonstrate, the new and often strained relationships among patients and professional groups are

being worked out within a larger context of shrinking resources and stalled policy initiatives. Medical personnel, lawyers, and most of the other professionals involved have been buffeted by major changes in funding priorities and regulatory policies over which they have relatively little control. In the absence of strong leadership from state and federal bodies, these professions have been called upon to play unprecedented, seldom acknowledged, and little appreciated roles as agents of fiscal and ethical accountability. Thus their conflicts with one another and the lay public reflect a shared expansion, some might say distortion, of their functions within the larger society.

In the creation of these new roles a number of changes have taken place. Among the most obvious and important are: experimentation with conflict resolution systems that provide an alternative to litigation; refinement of the existing system of tort law; the introduction of more formal systems for securing patient participation in medical decision-making through informed consent policies; and an expansion in the scope of such self-policing mechanisms as peer review and ethics committees.

What has not emerged is an attempt to coordinate or streamline these new institutional developments. In fact, they are being engineered in a political and professional milieu that discourages informed, dispassionate policy considerations. Instead, solutions are being hammered out in the intensive care unit and the courtroom, in the heat of the moment, with no concern about their long-term impact. An atmosphere of adversarial and self-interested thinking prevails that pits doctors against patients, doctors against lawyers, plaintiff bar against defense bar, lawyers against judges, ad infinitum. It is little wonder that all the parties involved — physicians, patients, and third party "referees" — as well as the general public, have become increasingly confused and hostile.

Finding "common ground" in this tension-filled atmosphere is not an easy task, as the essays that follow will attest. Yet, the conditions seemed right to bring together, in a non-adversarial setting, prominent local physicians, lawyers, insurance executives, judges, legislators, nurses, and academics concerned about the escalating costs and tensions involved in the mediation of doctor-patient conflict. For the first time a significant amount of research data is available about therapeutic interactions and the efficacy of current systems for malpractice resolution, so that "hard facts" rather than anecdotes can inform policy discussions. The crisis mentality that

has pervaded previous debates of doctor-patient conflict, particularly in the area of malpractice litigation, has also abated. Although most authorities in this area feel that this lull is only temporary, it does offer a chance for reflection and the seeking of a broader, long-range approach.

The purpose of this volume is to provide community and professional leaders with a perspective on developments which have deeply affected them in recent decades. By exploring the historical origins and sociological workings of responses to the doctor-patient crisis, we hope to promote a meaningful reconsideration of the problems that now exist, and stimulate creative suggestions for their solution.

The first essay sets the tone for the rest of the volume by provocatively announcing that the malpractice crisis is a minor problem in a health care system on the verge of collapse. The conference's keynote speaker, Columbia University economist Eli Ginzberg, believes that the current malpractice system is inefficient and costly, but it is only one small part of a health care system desperately in need of reform. The nature of this reform and how and when it would take place is the main topic of Ginzberg's address. In his "Interest Groups and Health Reform" Ginzberg presents an especially clear picture of the larger context of finance and public policy in which health care professionals and patients must operate. In an absorbing overview of the interest group politics involved in the formation of American health care policy, Ginzberg predicts that at the current rate of expenditure the United States health care system "will be derailed" before the end of the 1990s. The astute insights provided by this advisor to nine United States presidents into how the political economy of American health care works are compelling. They also give the subsequent discussion over the strains in the therapeutic relationship and the need for reform of the malpractice system a much more urgent tone.

The scholars who follow Ginzberg, particularly University of Pennsylvania sociologist Charles Bosk, and Columbia University professor of history and social medicine David Rothman, refine this portrait of a health care system in crisis. In their presentations the focus shifts away from politics and economics to center on some of the social and intellectual dynamics at work. For Bosk and Rothman the current medical malpractice situation presents some very real and acutely disturbing problems in communication.

Sociologist Bosk offers a thoughtful look into the minds of the two professions that have had the longest history of involvement with medical malpractice — medicine and the law. In his essay Bosk examines the differences in medical and legal ideas about "mistakes" and the impact these differences have on the resolution of doctor-patient conflicts. "For plaintiff's attorneys," Bosk observed, "it is the degree of damages alone and not the degree of negligence that determines the legal seriousness of a physician's error." The physicians, Bosk's research suggests, do the opposite and use "the amount and type of negligence" and not the "damage" to the individual patient "to determine the seriousness of an error."

The increasing power of this difference in medical and legal understanding to affect the doctor-patient relationship is made evident by Rothman in his account of how medical decision-making has changed since the 1940s. "Practically every development in medicine in post-World War II America," declares Rothman, "has distanced the physician and the hospital from the patient and community." Doctors, with their professional armamentaria of high technology and complex science, have become "strangers" to the lay public. The "personal connections" and "bonds of trust" that once characterized doctor-patient relationships, Rothman argues, have been replaced by a variety of legal and contractual ones that somehow seem inadequate.

These inadequacies were the focus for the conference's final session — a panel discussion of reform possibilities. The panelists included patient-consumer advocates Jan Cauffman, R.N., and Walter Lear, M.D., attorney James McCabe, Esq., state legislator James Greenwood, physician Richard Baron, M.D., and chief counsel for the Pennsylvania Medical Society Liability Insurance Company Sarah Lawhorne, Esq. During the discussion several intriguing questions were raised, but one of the most persistently troubling was the issue initially raised by Ginzberg about the importance of malpractice problems in the overall picture of health care delivery in the United States. This time, however, the question was expanded to include a corollary: how important is it to reform the existing system for handling doctor-patient conflicts? The answers to this question provided by the various panelists reveal not only a great deal about the improbability of reform, at least in the state of Pennsylvania, but about the tension between finance and humanity that lies at the root of many of America's most vexing health care problems. This tension runs through the statements of each of the

panelists even as they explore such diverse topics as the business community's need for predictability and rational risk; the patient's growing anxiety and feelings of powerlessness in the world of costly, high technology medicine; the medical community's growing frustration with a system that makes simultaneous demands for human sensitivity, fiscal responsibility, and scientific certainty; the legislator's need to balance the conflicting interests of lobbyists and constituents; and the legal profession's impassioned faith in its ancient and lucrative system of tort law. The discussion by the panelists and the various questions and comments made by the audience raised in a particularly poignant fashion the frustration experienced by all those faced with the task of providing or securing quality patient care in the expensive, technologically sophisticated, heavily regulated 1990s. It remains to be seen whether this frustration is powerful enough to inspire further discussion, or if the search for common ground ends here.

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Interest Groups and Health Reform

ELI GINZBERG

At the beginning of my discussion I wish to get a few things straight: Since the conference theme is medicine and law it is important to state that I have had few contacts with either field. I spent a single night of my life in a hospital a half century ago when my tonsils were pulled out. I did not sue at the time but today I might, because they should not have been removed. The closest I have come to the law was during my first year of teaching at Columbia University in New York in 1935, when I attended as a fringe benefit two courses in the Law School, more or less for fun. But as I did not find them that much fun, I stopped. One of my three children became a lawyer, but she found it dull and she is now a video producer. So it is clear that I am hardly qualified from personal experience to say much about medicine and the law.

Fortunately, my friend William Kissick gave me a much broader title for discussion, "Interest Groups and Health Reform," so that is what I will focus on. Since I am in Philadelphia, I have to begin by telling a true story because it involves medical care many years ago. My family were New Yorkers but my father's physician was a Philadelphian by the name of Solomon Solis-Cohen. He was a well-known internist and diagnostician and among the other judgments he made was that my father would not live much beyond his 50th year. In those days to tell a patient who had a much younger wife and a couple of children that he had a decade or so to live was hardly a reassuring prognosis. However, Dr. Solis-Cohen forgot to put my mother into his equation. My mother kept my father alive to a few weeks short of his 80th birthday. She, in turn, stayed alive until age ninety-four. Physicians are useful, but good genes, love, and devotion are powerful medicines.

In my discussion, I plan to do three things. First, I will explore what we mean by interest groups in the health care arena. Who are they, how do they act, what can or should a society do about them? Second, I will offer what I can by way of insights about the role of the different interested parties in the current policy arena. And then, at the end, I will advance some speculations about how the dominant interest groups are going to rub against each other during the remainder of this decade.

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Let me begin by saying some things that struck me as I tried to think my way through the thicket of interest groups and health care. It used to be very simple: there was the American Medical Association (AMA) and everything that happened or did not happen in American medicine could be traced back to the AMA. The AMA, for instance, really played the lead role in the reform of American medical education in the early part of this century; also, the AMA was semi-supportive of national health insurance between 1916 and 1919. That is a piece of history long since forgotten.

But many decades ago the AMA had to begin to share center stage. The Association of American Medical Colleges (AAMC) became a second important interest group, especially in the post-World War II years when the federal government started to finance medical research in a big way and put much of its money into the leading academic health centers. By way of background, the federal government spent $3 million on biomedical research in 1940, and it is spending about $12 billion today.[1] What is more, many leadership groups in Washington are reasonably certain that the United States government is underfunding biomedical research.

The next development involved the proliferation of the specialty societies and residency review committees. Together they usurped control over one half of American medical education, the critical years of clinical training.

Ever since I delivered the Martin Memorial Lecture some years ago to the American College of Surgeons I have been receiving their monthly publication, the *Bulletin of the American College of Surgeons*. Looking through the April and May issues, I found most, if not all, of the pages devoted to the planned adjustments that Medicare was about to make in establishing a single all-inclusive fee for surgical procedures. The articles read more like exercises in economics than medicine.

In addition to physicians, hospitals are clearly a second important interest group. However, it is not easy to define the key subgroups that are involved. When we talk about hospitals, are we referring to trustees? administrators? the physician staff? the nursing staff? technicians? the other support staff? If we consider that most of the people who sit on hospital boards as trustees or directors are leaders in local business enterprises, we will realize that they

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1. Eli Ginzberg and Anna Dutka, *The Financing of Biomedical Research* (Baltimore, Md.: Johns Hopkins University Press, 1989).

have conflicting interests. On the one hand, they buy health insurance for their workers, about which they are complaining legitimately that the premiums keep going up and up and up. And on the other hand, every month when they attend the hospital board meeting the administrator shows them that the hospital is having a hard time getting its revenues to match its expenditures. Clearly, there is nothing simple about defining the interests of at least one key group, the trustees. To confuse the picture a little more, consider the complaints of rural hospitals that Medicare has been setting the reimbursements for rural hospitals at too low a level relative to those received by urban hospitals. Further, consider that the Prospective Payment Assessment Commission (PROPAC; the official governmental body responsible for reviewing Medicare rates) believes that the federal government is allowing the urban hospitals a disproportionate share of add-ons that the cost figures do not justify. It is easy to see that there are a great many different interests in contention.

Now let us look at the patient's side of the equation. Between 1972 and 1988 Congress did not touch Medicare entitlements. In the latter year Congress decided to provide catastrophic benefits for acute care patients. But the elderly who were the prospective beneficiaries went out, organized, and forced the Congress, to my knowledge for the first time in American history, to rescind the new entitlements the following year. I could go on to explain that I had warned a Sub-Committee of the Ways and Means Committee several years earlier not to touch Medicare unless there was a lot of money available, but they forgot that advice and got mud all over themselves. Clearly, the concept of interest groups in the health care arena is complex. Congress one year adds benefits and the next year the beneficiaries insist that they should be rescinded.

Let us look next at the private health insurance sector. That is really what we depend on, at least most people below 65 years of age do. Private health insurance is, in considerable measure, a misnomer. The Federal government contributes $50 billion of subsidy annually to make the private health insurance system work.[2] Employers can deduct the cost of health care benefits as a business expense, and workers do not have to include the value of their benefits in their reported income. Even with that subsidy, private

2. Alain Enthoven, "Health Tax Policy Mismatch," *Health Affairs*, 1985, 4(4):5–13.

health insurance does not work very well. I am disturbed that the industry devotes more time and effort to avoiding the enrollment of high risk individuals than it does to designing and selling low cost policies to many of the uninsured who need catastrophic coverage at an affordable price. Once upon a time, the Blue Cross system went out of its way to enroll people on a community rating basis. In the last 15 to 20 years however, the commercial health insurance companies and many of the Blues, though not all, have been pursuing a risk management strategy. The United States is the only country that, having decided it did not want public health insurance and having opted for private health insurance, would tolerate the pursuit by its major insurance companies of a risk management strategy that makes it much more difficult for large groups of the population to obtain coverage. That is no small trick.

We do not usually think of government as an interest group, but it must be remembered that government has a special relationship to health care. Federal, state, and local governments together contribute 40 percent of all the monies going into health care. To give an idea of how much money this entails, total outlays for 1991 are estimated at $765 billion.[3] To put that figure in perspective, I should indicate that President Nixon made a speech in 1969 in which he said that if we did not control our health care spending, we would soon bankrupt the health care system and what is more, we might bankrupt the United States economy. In the following year, 1970, the United States spent $75 billion for health care, or 7.5 percent of its Gross National Product.[4] In 1991 the ratio is likely to be 12.4 percent.[5] Obviously, governments, as payers, have to worry about these matters. Further, there are conflicts of interest within the governmental structure. In the past two years, 48 out of 50 governors have petitioned the Congress and the White House to stop mandating new Medicaid benefits, because they, the governors, cannot come up with the additional revenue. Pennsylvania is currently having trouble meeting Medicaid reimbursements.

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3. U.S. Department of Commerce, "Health and Medical Services," in U.S. Department of Commerce, *United States Industrial Outlook, 1991* (Washington, D.C.: Government Printing Office, 1991), Chapter 44.

4. Helen C. Lazenby and Suzanne W. Letsch, "National Health Expenditures, 1989," *Health Care Financing Review,* 1990, *12*(2):1–26.

5. U.S. Department of Commerce, "Health and Medical Services," in U.S. Department of Commerce, *United States Industrial Outlook, 1991* (Washington, D.C.: Government Printing Office, 1991), Chapter 44.

One more point, in order to bring to the surface still another order of complexity: national health insurance first appeared on the American political agenda in 1912. Theodore Roosevelt ran for president on the Bull Moose ticket in that year, and he had national health insurance in his platform. Few people were much interested in "TR" at that point or in national health insurance, and the latter never got anywhere. I recently read a copy of President Harry Truman's 1945 proposal for national health insurance. Except for a few stylistic changes the same message could be reformulated in 1991, 46 years after Truman's initial proposal. The question that one needs to raise is why did the proposal die aborning? I have two answers.

First, the trade unions, the primary party of interest in pushing national health insurance, remained — except for a few leaders such as Walter Reuther — on the sidelines. The reason that they did was very simple: they found, after private health insurance was established, that their members wanted union leaders to negotiate better health benefits for them and that, in general, employers were cooperative. Many legitimate and some corrupt unions had leaders who recognized the additional power and influence that they could wield if they had a decision-making role in the investment of the union's health and welfare funds.

Second, once the hegemony of the AMA was destroyed, which was surely the case by 1965 after it lost its all-out effort to defeat Medicare, the organization has spoken with a soft voice and, I believe, a better voice. Dr. James S. Todd and I were consultants to Dr. W. C. Hsaio when he developed his resource-based relative value scale, and I thought Todd played a constructive role in developing the new fee and value measures. But the AMA does not have anywhere near the leverage in the political arena that it had before it put all of its chips into the defeat of Medicare and lost. If you go for broke and lose, you have demonstrated your weakness for all to see. National health insurance never had broad left-wing support, either, so we never got it.

To round out this line of interpretation let me add a point about the attitudes of Americans toward the poor. As a people we believe that everybody should have a maximum degree of freedom to prove what they can do and consequently, anyone who does not succeed is by definition at fault. The "great communicator," our last president Ronald Reagan, articulated this view not once but time, and again.

So much for the past. Now we come to a consideration of interest groups and health care reform today. I start with this proposition: two-thirds of the American people with good insurance coverage, either private health insurance and/or Medicare, are satisfied in the main with the health care system as it is working for them. That means that they have little or no interest in major health reform, unless and until they come to believe that their present coverage is in danger. I used to do a fair amount of overseas consultation for the Department of State and I always gave some thought as to where I wanted to be treated in case I had a medical emergency. While I was willing to consider treatment in Switzerland, Holland, and London, my preference was always to get back to the United States. That was a guiding principle which I fortunately never had to put to use.

The business community is split three ways in terms of the present situation. Employers who offer good benefits would like to see those of their peers who offer no benefits forced to do so, because otherwise they will continue to cross-subsidize these avoiders. In short, many favor a mandate that would require all employers to provide coverage for their workers or pay a special tax. The small employers are complaining that they cannot afford present insurance premiums and some say they cannot afford to provide any health benefits at all because they are working too close to the margin. If they had to pay something on the order of $1,500 per employee per year, that would tip their businesses into bankruptcy. Therefore, most small employers do not want to see any employer mandating initiative.

The large employers, who could get considerable help if they invited the federal and the state governments to collaborate with them in a conjoint effort to control the total flow of funds into the health care system, have up to the present resisted the temptation. They fear, and with good reason, that if government became an active partner in controlling health care costs and benefits, it would not be long before government might decide that it should play a more active role with regard to other benefits, such as pensions. And then it would be only a small step for government to want a voice in wage determination. Faced with these dangers, most private companies have decided, at least for the time being, to keep their distance from government.

The private health insurance sector, in my view, has performed poorly in recent decades, nor am I impressed with the overall

performance of American industry over the last 20 years. However, I believe that we are doing better now, and I hope we will do still better in the middle and latter nineties. The best evidence of how badly the private insurance companies performed is a reminder of how many large and medium-size employers decided to self-insure their workers. They saw no point in continuing to advance large sums to their insurers for the minimum services that they received in return.

I have read the testimony on small group policies recently given before the House Ways and Means Committee by Bernard Tresnowski, the head of the National Blue Cross-Blue Shield Association.[6] It was a statement that he should have given about 15 years earlier. My personal expert on private health insurance is Stanley Jones, who was the long-term vice president of Blue Cross in Washington. In a speech he gave a few months ago he concluded that he has almost given up on the capacity of private health insurance to meet its societal obligations. I have not quite given up, but I am pretty close.

As far as the physician community goes, I mentioned earlier that while the surgeons and primary care physicians avoided an open fight amongst themselves over attempts to redress relative reimbursements for procedural types, such as surgeons, and primary care types when the fee and volume control legislation was being passed, they remain very restive about the new system and spend a lot of time lobbying. Not long ago I was in West Virginia. As might be imagined, people in that state have all kinds of problems with prenatal care and deliveries in the mountain regions. Nevertheless, the West Virginia medical profession managed to defeat a nurse-midwifery bill, and in discussing the issue they contended that it was the lawyers' fault. I have a view that these two professions — medicine and law — are ultimately going to become allied; they may get together somewhere down the road and conjointly confront the rest of society in protecting their respective spheres of action. I am by no means sure that this will happen but it may.

I noted earlier, but it is worth repeating in the present context, that the biomedical research community in the principal academic health centers is a powerful interest group. Despite the fact that

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6. Bernard Tresnowski, *Testimony of the Blue Cross & Blue Shield Association before the Sub-Committee on Health, Committee on Ways and Means, U.S. House of Representatives, 102nd Congress, 2nd Session, 2 May 1991* (Washington, D.C.: Government Printing Office, 1991).

the federal government spends $11 billion on basic research and industry spends another $11 billion, the leadership of medicine says it needs more money for training, facilities, equipment, and grants. I am sure they can use more, but to an economist "need" is a more complex concept.

At last we have reached the finale; the role of the different interest groups in relation to health care reform in the 1990s. Some preliminary speculations about the 1990s: first, President George Bush will not take any lead regarding health care at this time, except for peripheral issues. That is my view of malpractice reform. I think we need malpractice reform; I think defensive medicine is costing us an arm and a leg, but in the broader picture of health care reform, malpractice is a peripheral issue. From my long-term experience in Washington where I worked for nine United States presidents, some smart and some not so smart, I doubt that any one of them would take the lead in health care reform at this moment. It is far from clear to me that either political party could gain much from trying to take the lead because it would be unable to develop a consensus on health care reform within its ranks.

But there is another part to this story. The forecast for 1994–1995, which is only three years away, is that we will reach the $1 trillion expenditure level for medical care. Joseph Califano used that figure recently in the *New York Times,* and it has been used by others as well.[7] Senator Everett Dirksen used to talk about $1 million here, $1 million there; now we have to talk about $10 billion, even a $100 billion extra. A $1 trillion expenditure for health care in 1994–1995 cannot fail to impress not only economists but everybody. But the more ominous estimates are the $1.5 trillion to $2 trillion by the end of the decade, only eight and a half years away. I believe $1.7 to $2 trillion will not be extractable from the American public. That means the system cannot continue on its present course.

I have recently looked at the data anew and thought my way through these forecasts. This audience is in on the creation, at least as far as Ginzberg is concerned: this is the first time that I have said definitively that our present health care system will be derailed. It cannot continue at this level of expenditure for another eight and a half years. That is my first speculation.

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7. Joseph A. Califano, Jr., "More Health Care for Less Money," *New York Times,* 14 May 1991, Section A, p. 19, Column 2.

My second speculation is closely linked to the derailment effect. The two-thirds of the American public that I earlier identified as being reasonably content with the quantity and quality of medical care that they are receiving will become anxious and concerned because of fears that their health benefits will be curtailed. In fact, some of the insured are currently at risk, having agreed to pay more toward their coverage or toward coverage for their dependents.

That brings me to my third speculation which is focused on what we might do to salvage as much as possible of the strengths of our system while at the same time making it more responsive to the one-third of the population who need more and better care. To do all of this will mean constrained expenditures. I would say that employers, the federal government, and the state governments have very little time left to figure out how to move towards a single payer system with global budgeting. I am glad to report that the Comptroller General of the United States in his recent (April) presentation to the Ways and Means Committee of the House of Representatives stressed the same goals.[8] In fact, he alerted the Congress that he would soon be back with the outlines of the actions they should take to assure the realization of these goals. Specifically, he said that we must provide health insurance coverage for the entire population; simplify the fantastically cumbersome and wasteful administrative structure with its hundreds of thousands of redundant personnel in middle management, in clerical roles in insurance companies, and in the arena of defensive medicine. A conservative estimate would suggest that a 20 percent savings should be within reach and 20 percent of our 1991 outlays comes to a hefty figure, over $150 billion annually! The Comptroller General ended with the importance of Congress establishing an annual budgetary cap on all health care expenditures.

I now come to my forecast: I think that the pot will boil over just before or after the 1996 election. We have only a very few years to see whether we can forestall the crisis or be overtaken by it and forced to slug it out in the political arena when it erupts. I have no reason to believe that slugging it out is a preferred way to go. I was convinced in the early 1960s that we needed to reform the system

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8. U.S. Accounting Office, *U.S. Health and Spending: Trends, Contributing Factors, and Proposals for Reform. Statement of Charles A. Bowsher, Comptroller General of the United States before the Committee on Ways and Means, House of Representatives, 102nd Congress, 2nd Session, 17 April 1991* (Washington, D.C.: Government Printing Office, 1991).

to help the elderly but I was opposed to what we got. I was a minority of one on the policy and planning committee of the New York Academy of Medicine; 64 voted for what we got and I stood up and said I was opposed to the federal government's paying for the medical care of Governor Nelson Rockefeller or even Professor Ginzberg. I was worried about what would happen. I thought I was better at arithmetic than President Lyndon Johnson's actuaries, and I thought they did not understand the consequences of attaching the new medical care financing system to the United States Treasury. I knew the lid was going to blow sooner or later; I am only surprised that the crisis has been forestalled for about three decades.

What are my final observations? I think we will pass something called national health insurance, some kind of federal-state minimum coverage package for everyone. It may be good for the people who currently have no insurance and it may even be good for those who are on Medicaid. But I seriously question that it will improve the situation of the two-thirds of the population that currently enjoys good health insurance coverage. Moreover, the morning after the new legislation is passed, millions of workers who currently have better benefits than the new federal-state system will provide, will start to renegotiate with their employers and their argument will go as follows: we worked for our benefits and accepted improved health benefits in lieu of higher wages. The fact that the federal government has passed national health insurance is okay but not germane to our position. We want you to cover our supplemental benefits so that we stay even. I am reasonably certain that this will happen.

With between 45 and 50 percent of post-tax income going to the top quintile of American households, it looks to me unlikely, to put it mildly, that that minority will not put additional money into the health care system. If this can help restore their health and improve their later years, why not? To put this last point in perspective, let me remind you that even Great Britain, which runs a low cost system in which equity is a key objective, has not been able to prevent the modest expansion of a second system of hospital care outside the National Health Service (NHS). When Margaret Thatcher required gynecological surgery, she did not wait in line for a year and a half to be admitted to a hospital. About 30 percent of all elective surgery in Great Britain is performed on people who opt out of the NHS to get treated expeditiously. One of the ways

the British system is balanced is that many people die waiting for admission to hospital. Death reduces the numbers in the queue. Another important balancing agent in Britain is the physician who never informs the older person that the renal dialysis he or she needs could prolong their lives. It is simply not available in the NHS. Clearly there are many ways of balancing a health care system.

I am always amazed when people in the United States say, "We do not want to ration in this country." Yet, we ration left and right, backwards and forwards, all the time. Although New York City spends about $2.5 billion annually on its public hospitals and clinics, many of the hospitals offer less than a minimally acceptable level of care. We have many problems that need attention beyond getting our financing in order and controlling the amount of new money that we will put into the health care system every year.

We need to close down hundreds of hospitals. We are not only overhospitalized in terms of beds, but we have expensive services in duplicate and triplicate that inflate our cost structure. The Medicare-Medicaid reforms initiated in 1965 helped to bring superior hospital care to every community of 50,000, and to many smaller communities. That is what we accomplished with the tremendously enlarged infusion of new money. We had the specialists, we had the sub-specialists, and we put the money on the barrelhead for many outlying hospitals to transform themselves into tertiary care facilities, thereby making life much more difficult for the inner city academic health centers. I lectured this past week at Children's Hospital in Boston. Children's is in the process of establishing clinics in the suburbs to increase the flow of patients into its inner city inpatient facility, an action that will almost certainly lead to some counter actions by the suburban hospitals and physicians. In Iowa recently I was told that the state has 99 counties, 91 of which contain a rural hospital. I asked how long it would take for the most isolated Iowa farmer to get to a hospital; the answer was 45 minutes. I pointed out that if I walked out of my house in Manhattan and were struck by a truck, I could not get into a hospital in less than 50 minutes.

Another illustration: Some years ago during a visit to the Johns Hopkins Hospital in Baltimore, I learned that a small local hospital a few blocks away was doing open-heart surgery and competing with Hopkins on the basis of price. I submit that there is probably no other city in the world that would expose one of its great teaching hospitals to such neighborhood competition. My associates and

I have just finished a four-metro study — New York, Los Angeles, Chicago, and Houston. In each of the four cities we found that the low-income areas in the inner city often have only one physician in private practice for 10,000 to 15,000 inhabitants. In the high income areas there is one physician for 600 to 1,000 population. And we say we do not ration! One of these days we will have to figure out a way of enticing, persuading, and bribing physicians to work at least for a time in underserved areas.

We may even want to consider shifting some dollars that we now use on therapeutics to the area of prevention. But if truth be told, I am skeptical about such a shift. The best preventive measure I know is to pick the right mother with the right genes. In the early 1970s the Minister of Health in Canada issued a document which pointed out that his country could save a lot of money and at the same time contribute to improving the health and longevity of its people if it shifted most of its outlays from therapeutics to prevention.[9] In discussing this proposal, I inquired what preventive measures of known efficacy Canada was ignoring. The answer, as might have been expected, was none that permitted of easy implementation. Admittedly, if one could get people to change their behavior, prevention would have a big pay-off. But Moses, Jesus, and Gandhi as well as many other great leaders have had limited success in the arena of behavioral change. All the same, it might be a good idea to move some money out of medicine and into welfare and education. The federal government probably contributed more to improving the health of the American people in the 1970s through the establishment of the food stamp program than by additional spending for health care services. At least, I am willing to defend that proposition.

Now to my peroration: Philadelphia is the city where the founding fathers directed their considerable talents to designing a unique system of government, a system of checks and balances that was aimed at protecting the people against the arbitrary exercise of power by elected and appointed officials. The Constitution that they designed was an outstanding accomplishment but it succeeded in giving us a government which was inherently constrained from being an efficient mechanism for the governance of a people that soon spanned a continent and that became the world's hegemonic

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9. Minister of Supply and Services, *The Lalonde Report: A New Perspective on the Health of Canadians* (Ottawa, Ontario: Information Canada, 1974).

power. Let me close by emphasizing that it is hard, probably impossible, to design an effective-efficient health care system in a society which has a governmental structure that at best works poorly.

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Mistaking Identity: Medical Errors, Physicians, and Plaintiff's Attorneys

CHARLES L. BOSK

It is not news that the once fraternal professions of law and medicine no longer model their relations with one another on the myth of Damon and Pythias, that mutual hostility has replaced filial appreciation as the predominant sentiment, and that one leading cause of this visible chill is the area of malpractice. What I intend to do in this essay is: (1) describe how doctors understand, use and apply such concepts as reasonable risk, fault, and negligence when assessing their work; (2) show how plaintiff's attorneys socially construct a very different reality than do defendant physicians and; (3) describe some consequences of this "normal, natural disagreement" about what constitutes a serious medical error.[1]

The description of how differently doctors and lawyers understand reasonable risk, fault, and negligence is based on first-hand observation of their shopfloor practices. As such, this is an analysis that excludes from consideration many relevant factors to understanding malpractice, among the most important of these is the behavior of third parties such as private insurers. Instead, this is an analysis rooted in the familiar tradition of Everett C. Hughes and his students for analyzing the problems of the workplace. It is influenced as well by the less familiar work of the Polish-born, Viennese-educated social theorist Gustav Icheiser, on the structural conditions that generate misunderstanding in human relationships.[2]

My familiarity with physician's concepts grows out of a two-year ethnographic study of what behaviors surgical residents are disciplined for by their superordinates, the teaching faculty; of how they are disciplined differentially for blameless and blameworthy error; and of how the process of professional socialization creates

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1. A companion set of questions would consider lawyer's error and lawyer's and doctor's view of it. Such an in-depth approach would appeal to a sense of symmetry, but would, unfortunately, go beyond the bounds of a "typical" journal length article.

2. Gustav Icheiser, *Appearance and Realities* (San Francisco, Calif.: Jossey Bass, 1970).

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both individual standards of good practice and collective norms for enforcing them.[3]

My understanding of a lawyer's view of what serious medical error is rests on an experiential base that is less clinical, more academic than is the case with physicians. I have taken the courses in torts and advanced torts at the University of Pennsylvania Law School. These courses introduced me to the legal doctrines which lawyers manipulate when reasoning about what constitutes negligence, allowed me to read some of the classic case materials which are part of the legal culture, and forced me to think about the duties and breaches of physicians from a perspective ruled by neither sociological nor medical prerogatives. In addition, I employed a "convenience" sample of acquaintances who are members of the bar and whose practices involve a significant amount of negligence work as plaintiff's attorneys to explore how the world of practice differs from the ordered and principled world of the legal casebook.[4]

How Physicians Define Errors

It is, of course, more than a bit presumptuous to speak of how physicians define errors. There is a great deal of variation among physicians by specialty, by practice type, by region, by sex, by age, by ethnicity, and by religion. Like the overall society the society of physicians is pluralistic.[5] As an occupational group, physicians display a Durkheimian organic solidarity.[6]

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3. Charles L. Bosk, *Forgive and Remember: Managing Medical Failure* (Chicago, Ill.: University of Chicago Press, 1979). Charles L. Bosk, "Social Controls and Physicians: The Oscillation of Cynicism and Idealism in Sociological Theory," in Judith Swazey and Stephen Scher, eds., *Social Controls in the Medical Profession* (Boston, Mass.: Oelgeschlager, Gunn, and Hain, 1985), pp. 31–52. Charles L. Bosk, "The Health Care System: An Overview," in J. Childress, W. Wadlington, and R. Gaare, eds., *Biolaw: A Legal and Ethical Reporter on Medicine and Bioengineering* (Frederick, Md.: University Press of America, 1986), pp. 9–26.

4. I call it a "convenience" sample to indicate some discomfort over generalizing from my sample (a small, select group of acquaintances) to either the plaintiff's bar or the legal profession. I have dealt with the logic and liabilities in using surgical residents to generalize about medical error elsewhere; Bosk, *Forgive and Remember,* pp. 27–32.

5. David Mechanic, "Physicians," in *Handbook of Health, Health Care, and the Health Professions* (New York: The Free Press, 1983), pp. 432–454. Bosk, "The Health Care System: An Overview," in Childress, Wadlington, and Gaare, eds., *Biolaw.*

6. Emile Durkheim, *The Division of Labor in Society* (New York: The Free Press, 1933).

Such solidarity is based on the seemingly spontaneous integration of multiple autonomous, inter-dependent, and impersonal parts; it produces a collective conscience which is diffuse, attenuated, and abstract. That is to say that when physicians catalogue error, they share no more in common than a few vague sentiments and ideals and that when physicians respond to error, they are doing no more than invoking a few vague adages, maxims, and gros-grained rules of thumb.

Most basic to physicians' definition of culpable error is the belief that outcomes are not directly related to quality of care. It is a fact, both of the state of the art in medicine and also of the human condition, that even the highest quality care will produce inevitable deaths and complications, pain and suffering, and unexplainable recoveries and demises. When physicians report to one another half in jest, half in mock protest, how their patients embarrassed them by dying in perfect electrolyte balance, they are suggesting that physician behavior did not create or contribute to that sad outcome. In general, physicians have a rather loose standard of liability in explaining bad outcomes. It is only very rarely that individual physicians are seen as making a mistake worthy of public censure and even rarer that such cases are acted upon.[7]

There are any number of reasons that bad outcomes — most deaths and complications — can be so easily discounted. First, patients are not innocent; sometimes their behavior confuses and confounds the physician's best efforts. Non-compliance with a therapeutic regimen — smoking, diet, exercise, general life style, and genetic predisposition — such factors as these frustrate efforts to tie too tight a knot between physician behavior and patient outcome. Further, the organization of care does not make it any easier to attribute individual responsibility. As Hughes first pointed out, the medical division of labor spreads the risk and blurs the responsibility for medical decision-making over a rather wide network.[8]

So it is only the very rare, bad outcome for physicians that raises questions about individual accountability. At this point, two questions suggest themselves: Exactly which bad outcomes need to

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7. Donald Light has found that for psychiatry a suicide is virtually required before the issue of physician error can even be raised. Additionally, once the issue is raised, it is quickly dropped. Donald Light, "Psychiatry and Suicide," *American Journal of Sociology,* 1972, 77:821–838.

8. Everett C. Hughes, *The Sociological Eye* (Chicago, Ill.: Aldine-Atherton, 1971).

be explained? And how do physicians deal with those in their ranks that commit these unpardonable sins?

The surgeons whom I observed were able to explain most deaths and complications. Failure of therapy to work was easily explained by technical or judgmental miscalculations which were reasonable given the situation at hand. Such mistakes were considered blameless, an unavoidable consequence of trying to make a living in so harrowing a profession as surgery.

Since "deaths and complications" are a routine part of major surgery and since they raise at least faint implications of error, how surgeons manage such occasions is important. The accounting for deaths and complications in the workplace either earns or forfeits for physicians the credit, trust, and high regard of their colleagues. For example, the resident whose inexperience has led to trouble can rescue the situation if he or she quickly recognizes a complication; promptly seeks appropriate help in treating the problem; extracts a general lesson from the clinical experience; and, perhaps most importantly, does not make the same mistake again on the same rotation.

The vast majority of deaths and complications that raise questions of residents' error fit this pattern and most mistakes are forgiven as blameless by attending surgeons. Likewise, the technical and judgmental failures of attending surgeons are neutralized when good reasons which support the course of action at the time are presented. For surgeons and most physicians, when the individual case is looked at closely enough, conditions which excuse possible misjudgment are discovered; for every patient there is a case waiting to be made.[9] Surgeons, in particular, and physicians in general, then excuse a lot of damages that occur to patients because of their artful appreciation of the full array of conditions which make healing at its best an imperfect art and the system of medical care an imperfect institution. As all those who work in them well know, the hospital houses a fair amount of normal disasters. Against this background physicians have little trouble excusing themselves for any added damages to patients, so long as theoretic and therapeutic rationales are found to explain what was done.

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9. In this way, the construction of surgical mistakes resembles the construction of psychiatric case histories which Erving Goffman describes. Erving Goffman, *Asylums* (New York: Anchor Books, 1961).

The fact that damages happened to someone is from the physician's point of view unfortunate but arbitrary, incidental and accidental. From inevitable deaths and complications physicians make the best of a bad situation; they learn a lesson that can be applied to future legions of patients. There is, so far as I know, no great sentiment among physicians that patients be compensated for the troubles that befall them in any greater measure than they already are. As we shall see when we examine the legal view of medical error, society is not always willing to be so forgiving of a physician's normal technical and judgmental error. As a result, physicians often feel victimized by malpractice suits: the sins of which they stand accused, in their minds, are nothing more than a reasonable set of decisions given what was known at the time; their troubles a result of running the odds one too many times; their fate to stand accused guilty of nothing more than standard practice in the community.

If, for most physicians, the vast majority of bad outcomes, deaths and complications, and sundry other dissatisfaction with care, are easily explained and denuded of any implications of culpable error, there are, nonetheless, some that are not. Just as physicians can enhance their reputations by the way in which they manage their mistakes, so too can they just as easily destroy them. To use the apprentice again as an example, residents who botch their mistakes earn the discredit, mistrust, and disdain of teaching faculty. In the program which I observed, such residents were typically viewed as unfit for the type of surgical career that the institution was preparing its residents to follow. They either continued their surgical training elsewhere or started their postgraduate careers over in different specialties within the same institution.

What was it that made it so hard to explain some deaths and complications, so difficult to divest them of their implications of culpable error? Blameworthy errors had features which violated either universal or local rules about how attendings organized their services. The following were the most common: a resident fails to recognize a complication promptly or attempts to cover one up; a resident fails to seek appropriate help; a resident fails to keep an attending surgeon informed of changes in the condition of his or her patients; a resident ignores, neglects, or overrides an attending's orders; and/or a resident makes the same mistake on more than one occasion. Blameworthy mistakes are not forgiven; they are taken as evidence that a resident is unteachable.

When residents make blameworthy mistakes, they are dropped from training programs. But what of attendings, what happens when their errors are culpable? First, it should be stated that colleagues monitor each other's performance less scrupulously and less routinely than they do that of residents.[10] Physicians in general, and surgeons in particular, value autonomy. A close knowledge of performance requires close surveillance, but such surveillance violates norms of autonomy and is viewed as uncollegial at best. As a result, it is rare that an attending surgeon is suspected of being the kind of person who can be counted upon to make blameworthy mistakes. Attendings are subject to a different supervision system than residents. This is one reason that their culpable error is more likely to be noticed by an outsider to the shopfloor — an administrator discovering a statistical outlier in a performance profile, or an attorney representing a plaintiff. Nonetheless, assume shopfloor notice that an "attending" is the kind of person who makes "serious" medical errors occurs. What happens then?

In response, attending colleagues can pursue a number of options. They gossip to friends. As a result, colleagues in adjacent fields may no longer refer patients. The attending may find himself assigned less attractive operating times or scrubbing with more capable senior residents. If offending residents can be summarily dropped from programs, offending attendings can be slowly eased out of hospitals. The upshot in either case is the same: physicians judged by their peers or teachers as the kind of individuals who make blameworthy mistakes are extruded from local practice networks. As Freidson and Rhea first pointed out, the primary processes of social control are boycott and exclusion.[11] Such dire remedies, are, however, rarely resorted to since most mistakes are easily explainable to physicians who face the same problems, run the same risks, and experience the same everyday problems.

There are two features about this system of social control which require further comment. First, sins which are punished in residents are often tolerated in colleagues, where they are seen as a matter of style, philosophy, or personality. What is insubordination by a resident is merely independent professional judgment in a colleague.

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10. Eliot Freidson, *Doctoring Together: A Study of Professional Social Control* (Chicago, Ill.: University of Chicago Press, 1975).

11. Eliot Freidson and B. Rhea, "Processes of Control in a Company of Equals," *Social Problems*, 1963, *11*:119–131.

Second, culpable error requires action only when it occurs within the boundaries of one's own hospital. The dumps, botched cases, and medical horror stories which were referred to the hospital in which the training program I observed was located, were commented on among the staff at the hospital. But for a variety of reasons, outside surgeons were never directly confronted with their misdeeds. Attending physicians felt they could vent any spleen necessary through the impersonal device of the follow-up letter.

It was alleged that honest practitioners learned lessons from these misadventures and were likely to stay within the limits of their skills. Sometimes, it was argued that unpleasant scenes with referring physicians were a form of bad manners that would discourage future referrals and leave patients without any hope of rescue. The economic consequences of this to the academic surgeons were real but went without saying. In addition, surgeons argued if a colleague were truly incorrigible any protest would likely fall upon deaf ears. Finally, surgeons pointed out that formal disciplinary proceedings were rarely warranted and generally so odious as to make the game no longer worth the candle. At no point have I ever observed any physician mention to any patient that another physician had, or might have, made a mistake in handling his case.

How Lawyers Define Medical Error

Patients seek out physicians for treatment of their bodily (and more than occasionally, their spiritual) ills. Clients approach lawyers to seek recovery from perceived damages. When a lawyer represents a client in a malpractice action, he or she attempts to convince a jury that it is reasonable to assume that the physician "harmed" a patient by failing to follow some obligation or standard of care and to recover from that jury damages which include medical costs, loss of earnings, and pain and suffering. Of these elements of a malpractice action all of my informants report that damages are more important than physician fault.[12]

The reasons for this are both theoretical and pragmatic. Perhaps most important is the fact that most malpractice suits are financed on a contingency fee basis. Lawyers have an interest in accepting only those cases where the lawyer's share of the take,

12. In legal casebooks and courses on torts, damages are typically given very short shrift. The emphasis on them in practice is one indicator of how the world of theory and the world of practice differ.

which as a matter of professional ethics cannot exceed 49 percent of the pot, promises to repay the investment of time necessary to prepare the case. One lawyer with whom I talked estimated that he accepted only one-quarter of those malpractice claimants who sought his counsel. Other attorneys with whom I spoke felt that the ratio of those who actually made a case over those who wished to do so was considerably lower — estimates ranged from one-in-ten to one-in-twenty. Patricia Danzon's estimate is one-in-ten.[13]

For plaintiff's attorneys, it is degree of damages more than the degree of negligence, that determines the legal seriousness of physician error. All of my informants agreed on this point. One claimed that if the injuries are serious enough he cares less about the adequacy of his theory of negligence; he is just anxious to get to a jury. Another claimed that the more serious the damages, the more he searches the record to find a case for negligence. A third simply stated that one purpose of the courts is to compensate victims and that, in general, the rule of negligence should be discarded.

All respondents reported on cases where they declined to sue, even though the negligence involved was gross, because the damages were slight. One of the cases, which involved a patient with a bullet lodged in him being discharged from hospital without an X-ray, is a good example of that want of care, thoroughness, and diligence which we found that physicians associated with serious errors. But since no damages attached to the negligence, there was no malpractice action. This alerts us to our first distinction between medical and legal definitions of error: physicians use the amount and type of negligence to determine the seriousness of an error while lawyers employ the standard of the extent of the damages. A small, trivial deviation from standard practice by a physician is a serious mistake to a lawyer if a patient is hurt badly enough. Conversely, a large, gross deviation from standard practice is trivial to a lawyer if no damages attach to it.

So it is the tail of damages that wags the dog of negligence in malpractice actions. The lawyer develops a theory of negligence in those cases where a first look at the record does not rule it out. Either the lawyer makes the decision that a case can be made, or an expert witness is consulted. Expert witnesses may advise lawyers that from their reading the patient's chart did indeed reveal negli-

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13. Patricia Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* (Cambridge, Mass.: Harvard University Press, 1985).

gence but that they would not so testify in court; or it revealed suspicion of negligence; or no evidence whatsoever of any negligence. In any case, lawyers need not accept the expert's opinion when damages are substantial. Plaintiff's attorneys are free to shop around until they find an expert who finds negligence and is willing to so testify. There are even services that will for a fee read charts to develop theories of negligence for trial lawyers and provide expert witnesses as well. The backs of trial lawyers' trade journals are filled with advertisements for such services.

Not surprisingly, lawyers place a premium on good experts who are described as well-prepared, enjoying the court room give and take, and as willing to state definitively that medical negligence has occurred. An operating rule of thumb of negligence that lawyers use in assessing the strengths of a case is: good damages, plus a good expert, plus a good trial attorney, equal money in the bank. (To a lawyer, a serious medical error occurs when all three appear on the scene at once. The rest of medical misadventure is so many trees falling in so many forests.)

Of the three elements that make a medical error serious, the first, clients with good damages, quite literally walks in off the streets. Although stories are rife among physicians of the sordid and sleazy practices lawyers use to recruit clients, most lawyers contend that the normal flow of humanity through their offices provides bounty enough. Almost all trial lawyers believe that they bring the third element of an unbeatable case to the court room themselves: they are the essential good attorney. In fact, a trial lawyer without this conviction probably is as ineffective as the shaman Claude Levi-Strauss described who had lost faith in his curative powers or a surgeon who had lost confidence in his ability to operate.[14] Lawyers and surgeons are so frequently adversaries because both practice crafts where their skills and their beliefs about them encourage them to take risky action.[15] The action that surgeons love — operations — creates the action that lawyers love — trials.

The lawyer's biggest problem in constructing the "bankable" case, then, is in finding the second element, the good expert witness. Moreover, the difficulties here appear to increase with the promi-

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14. Claude Levi-Strauss, *Structural Anthropology* (New York: Basic Books, 1963).

15. Erving Goffman, *Interaction Ritual* (New York: Pantheon Books, 1967).

nence, in local and national networks, of the physician being sued. The malpractice risks that prominent surgeons face because they operate more often on more difficult cases are balanced by the protection their reputations afford. Local stars are not likely to face local experts but national experts imported especially for the occasion. In a malpractice action national prominence makes it most difficult to find cooperative experts; local isolation makes it easier, but not necessarily unproblematic.

While there are many reasons given for the rise in malpractice suits, reasons which run the gamut from increasing consumer litigiousness to the growth of no-fault automobile insurance, one important source is a change in legal rules themselves. Until the 1960s, a "locality" rule was in force in most state jurisdictions — this meant that experts had to be local physicians familiar with community standards. This rule was first overturned in a Massachusetts case (Brune v. Belinkoff, 354 Mass. 102 [1968]) which declared "the time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases." Most other state jurisdictions have followed Massachusetts's lead. The reach of the rule has extended beyond physician specialists to hospitals (Darlington v. Charleston Community Memorial Hospital, 33 Ill. 2d 326 [1965]). Increasingly, the proper standard of care is a uniform national one. This change in legal rules has, on the one hand, imposed higher standards on physicians, and, on the other, helped make available expert witnesses who need not fear local reprisals. Further, it creates a standard that many local institutions do not have the resources to match.

As important as an expert witness is, if attorneys cannot find a good one, he or she will go with a bad one; as important as physician negligence is, if attorneys lack strong evidence, they will provide weak evidence so long as the damages are considerable, and so long as their client is a good one — sympathetic, spontaneous, and engaging, with a creditable, sad story full of pain and suffering. The strategy here is centered on making the client's case for compensation for damages incurred. Lawyers stress that they routinely emphasize that a finding of negligence does not mean that a physician is incompetent. Rather, they argue that negligence is human, that no one is error free. Like surgeons, they argue that errors are an inevitable fact of life in a profession so fraught with difficulty as medicine.

Where plaintiff's attorneys differ from the surgeons, who trouble themselves little with the cost to victims of inevitable error, is that attorneys believe patients are entitled to compensations from human error. In malpractice cases, attorneys trust that the damages speak louder to the juries than does the negligence. They need only make out a case for the negligence and the damages as it were, both speak for themselves and are richly embellished by the lawyer's peroration.

Some Concluding Observations

Both lawyers and physicians believe that physicians need to be accountable for medical negligence. After that, all agreement ends. What to a plaintiff's attorney is negligence is often to a physician action safely within the community standard. For physicians, medical negligence damages the honor of the profession. Redress comes when the offending party is banished from the group. The stain erased, the group regains its moral purity. For lawyers, medical negligence damages patients. Redress comes when these innocent victims are awarded compensation for their pain and suffering. By placing a precise cash value on that which traditionally defies calculation — the value and worth of the individual — compensation is a clumsy attempt to restore the world to its pre-negligence state.

Physicians rarely find negligence in the world of medicine; lawyers find negligence much more frequently. In fact, given their work, all some lawyers ever see of medical practice is negligence, save, one hopes, the medical encounters of their family and friends. I could expand this list with great ease, but the task at hand is not merely to generate a list to display how differently physicians and lawyers understand, use, and apply terms like negligence and serious error. It is also to describe some consequences of those differences.

The medical view of negligence and serious error obscures the patient from sight. The offense is to group norms for treating patients. The consequences of such offenses are not dwelt upon. Individual patients are not informed of serious error, and individual patients are not compensated for these errors, excepting that extra attention which a guilty conscience may occasionally provide. Physicians think about the pain and suffering of patients probabilistically, as something that occurs on average, in a sample, and anonymously. Serious error often harms patients, but a physician does not judge

an error as serious on that account. From the sociologist's point of view, what is most striking about the medical view of serious error is the collective denial of the patient's pain and suffering. Given the complexities, pressures, and multiple demands made upon medical professionals, this behavior is understandable. Nonetheless, the group taboo that is operative here is impressive to behold.

If the medical view of serious error obscures the patients, the legal view underlines them. Without significant pain and suffering, there is not a malpractice case; without its dramatization, there is no trial. Malpractice actions make public what physicians consistently deny: that the harm done by medical error falls upon particular patients, alters individual life courses, and is irrevocable. It is the lawyers' routine violation of the taboo against making such knowledge public that gets to the heart of legal-medical relations. For the physician, it is one thing to store the lessons of inevitable miscalculation in one's conscience, and quite another to stand publicly accused and judged guilty of them. Lawyers often bring physicians face-to-face with their own worst nightmares. Physicians are not as a rule grateful for this character-building experience. Moreover, malpractice actions are great levellers; since damages and negligence occur in the law without a finding of more general incompetence, even the most blameless physicians are reminded by the most unscrupulous of lawyers that they are not free from sin, and that even the most well-intentioned decisions potentially carry disastrous consequences.

Neither the medical profession nor the legal profession has a precise definition of serious error and negligence, despite their daily need to refer to such concepts. The medical profession defines as "serious errors" or "negligence" a whole range of behaviors that operationally add up to conduct unbecoming of a physician. Lawyers use the formulation that a physician is negligent when he or she breaches a duty owed to the patient. Both definitions require cases with their treasure trove of evidence before they can be used. Physicians debate among themselves whether a death or complication was the result of negligent errors. Plaintiff's attorneys make the discussion more public.

The absence of more precise criteria for error serves both groups well. On the one hand, it allows physicians to overlook much of what one, with firmer criteria, would have to admit was negligence. On the other hand, it allows lawyers to cast a wide net

in their legal actions, especially those where the damages are so great that the search is likely to be profitable.

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Suing the Stranger

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A historian who has been following trends in medicine can contribute significantly to a discussion of medical malpractice. Much of the writing that one reads about this subject has a mechanical quality, as if it were all a matter of opportunity and response. As policy-makers enter the malpractice area, they think that reducing contingency fees or putting a cap on awards will automatically discourage lawyers from bringing suit. I am sure that these are clever schemes that may indeed go a long way towards solving the problems. But from my perspective, they all make the subject of malpractice seem too rational, fitting within what I think of as a "economic man" model, as though people behaved logically and always made the correct economic choice. My sense, however, is that malpractice is not readily subject to a mechanical fix, that in tinkering with one or the other procedure in the hopes of diminishing malpractice suits, the results may differ from what was expected.

I can actually formulate my argument in a phrase: from my perspective, you sue a stranger, and doctors have become strangers to patients over the past 30 years. This change is what underlies the difficulties and the problems of malpractice. It is now known from recent studies that the amount of medical error is greater than the number of suits brought; this is not only because lawyers turn prospective clients away, but because not everybody who has been the subject of what might seem to be or what is incorrect medical treatment sues. Most of Charles Bosk's examples of well-regulated physicians came from the world of surgery,[1] and therefore did not take into account those physicians referred to scornfully by university hospital house staff as "LMDs" — local medical doctors, who remain outside most kinds of regulatory processes. Look at them and a very different picture of the quality of medical practice emerges. And yet, LMDs are rarely the subjects of suits. So too, one can talk about untoward outcomes, but is there any specialty which is less prone to do anything approximating an outcome measure than psychiatry, and yet psychiatrists are very rarely sued. Surely if outcome and process are not the magic formula determining the

1. Charles L. Bosk, *Forgive and Remember: Managing Medical Failure* (Chicago, Ill.: University of Chicago Press, 1979).

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probability of malpractice suits, the issue may well fit into the context of the doctor as stranger and the hospital as a strange place. I think my formulation will help in the understanding of the origins of patients' rights, the rise of bioethics, and the intervention of court decisions prospectively (as in terms of termination of treatment questions), and I hope it will assist in the understanding of the malpractice issue as well.

In a limited compass it is not possible to do a real "before" and "after" comparison, but I want to trace some of what I think are the major characteristics of medicine as the field has emerged over the 1960s, 1970s, and 1980s. There is an implicit comparison in some of my comments to the past, not out of nostalgia, but to give a sense of the nature of that change. I am persuaded that practically every development in medicine in post-World War II America has distanced the physician and the hospital from the patient and the community; this has disrupted personal connections and severed bonds of trust. Whether the index is friendship, religion, ethnicity, or intellectual activity, there is a sharp division between the lay world and the medical world. The two have moved so far apart in so many areas that the change is quite remarkable.

In lecturing to a general audience, I will sometimes ask, "With the exception of college roommates and psychiatrists, when is the last time that you spoke to a doctor and you had your clothes on?" Most often, I get a scratch of the head; most lay people and doctors do not mix socially. If the same question is asked of a group of doctors, the answers are very much the same. Indeed, when I moved from the Arts and Sciences campus of Columbia University — in New York at 116th Street — to the medical campus at 168th Street, I discovered how separate are those universes. When I was invited to dinner by my new medical colleagues, inevitably I was the only non-physician present. Yes, jockeys talk only to jockeys and ballet dancers to ballet dancers, but even by those standards the social isolation of the physician is quite extraordinary.

As for the strangeness of the hospital, let me offer a quotation from Meg Greenfield, a writer for *Newsweek*. After a hospital stay she wrote a column, entitled "The Land of the Hospital." She "had just come back from a foreign place worth reporting on, a universe really on its own, where one is a tourist in an unfathomable and

dangerous land."[2] There are a spate of medical self-help books to advise patients on how to manage their stay in a hospital. I am convinced that the books that provide information on how to trek through Nepal are simpler, although their advice bears a series of comparisons with that for hospital patients: bring food, organize family and friends. It is truly easier to go to Nepal, and in some ways a lot less scary too. I even developed my own series of strategies for friends who were unfortunate enough to be going into a hospital. My advice was quite simple: if you are married, spouse has a cot put into the room and spouse does not leave for the entire stay of hospitalization. What if you are not married? I suggest surrogate wives for the purpose of hospitalization. Always, always bring pictures and put them up — if you do not have children, use pictures of other people's kids. House staff must know that you are a valued person. A few diplomas do not hurt, but I will leave it to the lawyers and doctors to decide as to whether displaying a legal diploma on the wall would or would not be beneficial to patients' health. Certainly they might obtain a few extra diagnostic tests, but they might also be in a constant state of panic as to whether someone was going to try and even a score.

What I am raising, and what the Greenfield lines raised, is the extraordinary impersonality of the hospital setting. Being treated by strangers in a strange environment is a characteristic of contemporary medicine, and I think this distancing helps to explain why there is a new style of patient, why so many outsiders have come into the medical arena, and why we have an explosion of malpractice suits. I think it also explains our commitment to a more formal and collective type of medical decision making, including administrative guidelines, review committee oversight, and much greater readiness to bring in committees and have more eyes around the bedside. In the old days, the relationship was essentially a dyad, doctor and patient, with the doctor holding all the cards and making decisions with discretion. By now, there are many strangers in the patient's room, whether it is lawyers, government officials, peer review officials, or hospital ethics committees: physicians have a fair claim that the room is so crowded that they sometimes have a hard time squeezing in.[3]

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2. Meg Greenfield, "The Land of the Hospital," *Newsweek,* 30 June 1986, p. 74.

3. David Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991).

As some older Americans can actually remember, there was a time in this country when physicians made housecalls. But by the 1960s, patients were seeing doctors almost exclusively in offices or hospitals. The degree of specialization and subspecialization that has occurred in the post-World War II period has also transformed the profession. One hears complaints in the 1920s and 1930s about a new kind of specialization. But the data indicates that the overwhelming number of physicians characterized themselves as general practitioners, and that most "specialists" in the 1930s were in pediatrics or obstetrics and gynecology — which again had a very different connotation and a very different social context than the one we are talking about now. What this current degree of specialization means, from my perspective, is that when the stakes get high, when the illness is really serious, it is very likely that the person with whom the patient will be talking is a stranger.[4] I do not have to rehearse the history of the decline of the primary physician; a few of us may be lucky enough still to have one. But we do not know in advance which organ will fail us, whether it will be the kidney, the heart, or the liver: so if one becomes seriously ill, one will end up with a specialist who most probably will be a stranger. I have often worried about the world of Baby Doe and what authority should be given to the parents of a handicapped newborn. But my heart has always gone out to people in this situation because, inevitably, almost all of them did not know that the birth would be an untoward event, and that they would have need of a neonatologist. These parents are put in the position of having to make extraordinary decisions, face to face with someone who is a total stranger.

For many people, even having a primary care physician does not help because, in an acute illness such as a heart attack, they may end up in a hospital where their physician does not have privileges; and even if their physician is on staff, it will not be their primary physician who takes care of them in the intensive care unit. So again, as the stakes get higher, it is all the more likely that a patient needing medical care will be confronting a stranger.

Moreover, medicine in the post-World War II period, generally to its credit, has become a profession in which merit is probably better rewarded than in any other profession. Obviously Old Boy (not yet Old Girl) networks survive, and surgeons and psychiatrists have their own styles, but merit goes a very long way in the develop-

4. Ibid.

ment of a successful medical career. What this means, of course, is that the old days in which hospitals made their staff appointments on the basis of social class, family background, or ethnic identification are over. I can get a good laugh at 168th Street, where the hospital is officially known as Presbyterian Hospital, by asking "will somebody tell me one thing that is now Presbyterian about Presbyterian Hospital?" In New York not too long ago, Montefiore Hospital, founded under Jewish auspices, celebrated its one hundredth anniversary and took that occasion to abolish from its charter the provision that a majority of its trustees must be Jewish. At Mount Sinai hospital, in New York, the overwhelming majority of its patients are not Jewish; Catholic hospitals to a limited degree have withstood some of these trends, but on the whole the ethnic tie has dropped out of hospital life almost altogether. Simultaneously, preferential treatment on the basis of social class or family background has also disappeared. I hear stories from people who are not that much older than I of what it was like to apply for house staff positions at Presbyterian in the 1930s. The degree of discrimination was keen: this was a cohort of Protestants, well-born, tall, preferably blonde, and crew athletes; be short, stocky, curly-haired, or dark-skinned and Presbyterian was not the place for you. That sort of selection process is now over, and normally such a change would be cause for celebration. But in my context it has an alternate meaning, and that is that one can no longer be assured of having anything in common — social class, social background, religion, or education — with the treating physician. It is all encounters with strangers.

The distance between doctor and patient is only enlarged, and if anything made almost impossible to bridge, by the nature of the inpatient population in a hospital and by the nature of the drive to maintain a practice in an office. Doctors see more and more patients; and in hospitals the degree of illness has increased, so the element of speed in medical practice is vital. Medical interventions are also of a different order. Compare the treatment of a heart attack in 1935 with the treatment of a heart attack today. Back in the old days it was the most leisurely of phenomenon — a month in the hospital; now it involves literally split-second decisions by the doctor in a very short period of time. The entire pace of medical practice

is different, so that even if a doctor has the inclination to talk to the patient, it is an interruption of an incredibly scheduled pace.[5]

Moreover, and here I will be anecdotal, on rounds I have watched, again and again, how younger physicians are not at all interested in the patient's self-description because the patient is not a very interesting informant on the nature of the disease. In 1935, if a physician had a patient with chest pains he (and it was primarily he) had a lot of questions to ask. He would take a detailed case history not because he was necessarily a "humane" physician but because he had to talk to the patient if he was going to find out about the illness. Now, however, what can the patient possibly tell a physician that the CAT scan or the NMR is not going to reveal more clearly? The patient, diagnostically speaking, is often uninteresting. So while older physicians will make up aphorisms to try and engage house staff — always "take a tip from the jockey" — on rounds I watch the house staff standing there tapping their feet, wondering when the senior physician will be through so that they can move on. What this means is that in the 1930s and 1940s, the notion of patient-doctor communication did not have to take on a whole special cadre of concerns because it was a necessary part of the practice. Now proper communication skills must be actively taught because history taking from the patient appears to house staff and to younger physicians to be irrelevant. To them, it seems more of an indulgence than anything else.

These changes and the distancing of doctor from patient are largely the result of the kind of training physicians receive and the manner in which they are recruited to the profession. Several years ago, to investigate when medical aspirations appeared, I took a sample of convenience, as Charles Bosk has called it. I turned to my 15-year-old daughter, who was accustomed to being used as a sample of convenience by her father, and I asked her how many students in her high school class were going to become doctors. (I am assuming doctors take bloods from their children if they need a sample of normal blood so I have never felt very guilty about the questioning.) Instead of telling me to get lost as she might have done, she answered my question by listing eight names. Obviously, I had no way of knowing if she was right, but what was fascinating to me was that she already had in mind a cohort: those eight classmates will become pre-medical students, and then will become

5. Ibid.

doctors. I believe the decision to become a doctor is made at a very young age. There is good sociological survey data on this, but rather than giving the numbers to substantiate the point I will offer instead the quip: "Kids decide to become doctors about two months after they get out of diapers, and kids decide to become lawyers the day before the law school semester opens."

Similarly, the educational track that these students take — the only comparable group as excluded from the normal pace of college routines are athletes — is separate. If the premeds need a course, most colleges will substitute a course tailored for them. Therefore there is physics for the premeds and physics for other students, chemistry for the premeds and chemistry for other students. And I do not have to remind anyone of the nature of the competition in premedical school classes. By the time students are in medical school they are completely encapsulated. Charles Bosk has referred to the demands of physicians' work schedules, and even in New York, where we have cut down some of the hours of house staff, residents are engrossed in their own universe. Let the student then become a physician, a young physician, and the title of one sociological study says it all: "Married to their Careers."[6] The amount of divorce, alcoholism, and drug abuse among physicians is very high and may reflect this narrowness of education and outlook. There is even a kind of standard within medicine that approves of the isolation. To read commencement speeches is to learn that if you are a doctor, you should forget about theater, about ballet, or any other diversion.

I do not want to make it appear that the isolation of the physician is exclusively self-imposed, because this isolation is fully granted by the lay world to the medical world, the primary reason being that the substance of medicine is not what most people want to hear about in the normal course of things. The discourse of medicine after all, includes victories, to be sure, but also pain, illness, suffering, and death. This is not welcomed in dinner party or other social conversations. For a long time I was a professor of history at Columbia, and then I was asked to go up to the medical school to run a program bringing the social sciences and the humanities into the medical school curriculum. I was in the strange situation of not having been part of medical culture, and then suddenly being dropped into it. My first assignment was to meet with all the chiefs

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6. Lane A. Gerber, *Married to Their Careers* (New York: Tavistock Publications, 1983).

of service, and they were invariably polite, although that is not quite the way I saw it at the time. I would say my three lines, they would say their three lines, and then because I had been allotted half an hour on their calendar, they would start to talk shoptalk. At first I thought they were testing me to see if I had the right stuff, because the shoptalk was always about the "interesting case," and the interesting case was always one that from an ordinary commonsensical position represented an unmitigated disaster. Interesting case meant that they did not know what was going on, and that the patient was in deep trouble. (Not too long ago I had the occasion to address a graduating group of medical students at an informal setting, and my closing benediction was "May you never be an interesting case.") After many repetitions of the same experience with various chiefs of service, I came to realize that I was really not being tested at all, but I was being brought into their world, I was learning "this is what we talk about." Then I would go home, perhaps go to a dinner party of non-medical people and start to tell everybody about this case I had heard . . . . By the third time I did it, my wife let me know how unwelcome I was becoming. I came to recognize that it is not that doctor's shoptalk is boring, it is that doctor's shoptalk is terrifying. People do not want to hear about it if they are not doctors. Turn the point around and recognize that if you are a doctor, you find that the only people with whom you can talk about the things that are interesting to you are other doctors. All of which means that if the doctor is a stranger, it is not just the doctors who have marked themselves off from the lay world, the lay world too has been perfectly content to segregate illness.

There is a kind of magical disappearance of the physician from contemporary literature as well. I offer one example from among my favorites. The novelist Alice Adams has written a book about five graduates of Radcliffe (you know the genre), but the book quickly becomes a story about four graduates of Radcliffe because one of the graduates goes into medicine whereupon she disappears completely from the novel. It is now difficult to bring a doctor into a novel unless he or she is pictured in the hospital with a white coat on, otherwise you have to explain how it is that this doctor has come to this particular gathering and it demands too much exposition. It is much easier simply to exclude doctors and be done with it. One of the best novels I can recommend to illustrate all the nuances and byplay of medicine is Philip Roth's *The Anatomy Lesson*. Roth's protagonist, Zuckerman, dallies with going to medical school in

middle age, and he provides a wonderful kind of description of why medicine stays outside the purview of everyday life.

One final element which should be noted is that during the late 1960s and early 1970s the doctor became defined as "male" and that feminist critiques underscored him as a male stranger and therefore all the more suspect. The first edition of *Our Bodies, Ourselves,* the feminist self-help medical guide, contains this description (in later editions it has been toned down): "The image and myth of the doctor as humanitarian, which has been so assiduously sold to the American public for the last 50 years, is out of date. If there ever were such doctors they are all mostly gone now. Men in practice today most closely resemble the American business man, repressed, compulsive, and more interested in money and the disease process than in people. Medical students are usually very carefully selected by men who are attempting to reproduce themselves and usually succeed. After four years of training they have invariably become even more detached and mechanistic than they were to start with. As a group they are also more immature emotionally and sexually than their peers, or the rest of the population. Most doctors finishing their training are in late adolescence, psychologically speaking."[7] And the conclusion: "We want you to be more alert to your responsibility in the relationship, just as you would be in any other adult relationship in which you are purchasing services." This is the patient not as patient but as consumer, and the physician not as physician but as just this side of a used car salesman.

In light of these changes, the increase in malpractice litigation does not seem to me difficult to explain. I, as patient, have no compunction about suing because the subject of my suit is not someone I know, not someone I care for, not my primary care physician, and not my psychiatrist — it is a stranger. I have no kinship with that stranger, no kinship with the medical profession, and I am perfectly content to make this a cash transaction in which a lawyer will take x, I will get y. The increase in medical malpractice suits parallels almost precisely the evolution of the doctor as stranger. It is very difficult to measure this increase in litigation because record keeping is so varied, but by 1969 a congressional committee, chaired by Senator Abraham Ribicoff, was examining the role that the federal government might play in resolving mal-

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7. Boston Women's Health Book Collective, *Our Bodies, Ourselves* (New York: Boston Women's Health Book Collective, 1971), pp. 252–253.

practice issues. Richard Nixon appointed a Health, Education, and Welfare committee to study the causes of malpractice and to issue recommendations. And the American Medical Association, by the late 1960s and early 1970s, was also becoming involved. I conclude with a line that comes not from a bioethicist or consumer advocate but from an expert in malpractice law who is called upon to tell doctors how to behave. "When the physician-patient rapport remains at a high level of trust and confidence, most patients will ride out a bad result. But when that rapport is inadequate in the beginning, or is permitted to deteriorate en route, a suit is likely to follow."[8] Or in other words, if the doctor is a stranger, if the doctor has failed to establish rapport, the result is far more likely to be a suit. This is a very different perspective from concentrating on how to alter contingency fees or cap the amounts of awards in the hope of reducing the number of malpractice suits.

Center for the Study of Society & Medicine
Columbia University
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630 W. 168th Street
New York, NY 10032

8. R. Crawford Morris, "Law and Medicine: Problems of Malpractice Insurance," *Journal of the American Medical Association*, 1971, *215*:843.

The Cultures of Conflict Resolution: A Panel Discussion

MODERATOR

Richard G. Lonsdorf, M.D., Professor of Psychiatry and Law at the University of Pennsylvania.

PANELISTS

Sarah H. Lawhorne, Esq., Vice President, Secretary, and General Counsel to the Pennsylvania Medical Society Liability Insurance Company.

Richard J. Baron, M.D., Medical Director of Health Partners of Philadelphia and Clinical Assistant Professor of Medicine at the Medical College of Pennsylvania.

Walter J. Lear, M.D., President of the Institute of Social Medicine and Community Health.

James J. McCabe, Esq., Chief of the Litigation Department at the Philadelphia law firm of Duane, Morris & Heckscher.

Jan Cauffman, R.N., M.S.N., Executive Director of the Delaware Valley Ethics Committee Network.

James C. Greenwood, Pennsylvania State Senator from Bucks County.

Richard Lonsdorf: Everybody agrees that the present medical malpractice system in America does not work very well. There are many proposals to improve the system, but no consensus on which one is the best. The aim for our panel discussion is not to achieve consensus but for panelists to spell out a range of views from their different perspectives as to what ought to be done. Possible reforms include pre-trial screening; limiting the amount of attorney's fees or the size of awards, especially those for pain and suffering; regulation of expert witnesses and allowing only those with special credentials to testify; compensation of those injured by adverse medical outcomes regardless of establishing fault; and moving away from the tort

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system entirely. Procedures in other countries such as Canada, Great Britain, Sweden, or New Zealand could be imitated.

The Bush administration has come out with its proposals for reform: these are to limit the amount of money that malpractice victims can collect for pain and suffering, to require monies awarded to be paid not in a lump sum but in periodic payments over time; to establish alternative mechanisms of dispute resolution, such as arbitration or mediation, that must be tested before suits will be permitted to go to trial; and to strengthen medical licensing boards to establish firmer guidelines for clinical practice. And while the administration cannot force states to pass measures like these, it can penalize those who do not comply by reducing federal participation in the Medicare/Medicaid program. All of these reforms and others have been proposed before and the discussion at this conference offers an opportunity to examine some of these proposals.

Sarah Lawhorne: As my contribution to the panel discussion I want to give a brief capsule account of how we set insurance rates, then indicate what kinds of things affect rates, and finally list some specific tort reforms that would be useful. When an insurance company such as the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) sets a rate, we have to make sure that our income, which comes either from premiums or investments, will cover our operating expenses, our claims expenses, and for those companies which have a profit motive, the profit margin. In theory our rates should be set properly the year that we set them. By this I mean that what we collect in income in 1991 should be sufficient to cover every claim that will ever be attributed to that policy year. But, as it can take five to seven years for a claim to go through the courts, it can take approximately 15 years to close the books on a policy year. Therefore, in order to set the insurance rates for malpractice for a single policy year, we have to take historical data and project it out for up to 15 years. For example, we will have to pay for attorneys' time over those 15 years, and we will have to take into account the development of new medical procedures that may have been only theoretical at the time of the injury but which plaintiff's attorneys nonetheless apply to liability judgments.

If there is a substantial award in a malpractice case, it not only changes public perceptions, it affects the amounts plaintiffs and their attorneys expect in settling other similar cases, and also what our claims examiners are willing to pay to protect us from a charge

of bad faith if we make a mistake. Insurance companies have to deal with new theories of law introduced by plaintiffs and adopted by the courts, and different theories of damages. For example, about 10 years ago the Supreme Court of Pennsylvania stopped reducing the amounts awarded to reflect earning value over time, and this pushed up dramatically what insurance companies had to pay out. We have to accommodate new court interpretations of policy language that take advantage of ambiguities in order to achieve public policy results. If there is a downturn in our investment income, we have to make up the shortfall through higher premium rates. And finally, and certainly not least, our malpractice business is cyclical; we have periods when the frequency of suits goes down, followed by the rates a couple of years later; but by the time our actuaries tell us it is safe to reduce rates, the frequency of suits will begin to rise again. Right now we are going through a period where the Medical Professional Liability Catastrophe Loss Fund (CAT fund) is down, rates are down, and so, many people think there is no need to worry about tort reform. But it will not last: frequency of suits is going up again.

Therefore the PMSLIC formula becomes: premium income plus investment income should equal claims expenses, operating expenses, and a little contingency fund for judicial generosity and legislative largesse. It is always difficult to determine exactly how much to allow for the latter. But the things that would help us set our rates appropriately would also help the physician community as well. Insurance companies need predictability: we want to know when we will have to pay what. The more that malpractice reform can ensure this predictability, especially if it can be done without detracting in any way from the amount a plaintiff can recover, the better we will be at setting our rates, at monitoring what is happening, and also at evaluating when a patient will be paid and how much. We need efficiency. To obtain it, I would recommend to physicians in the community that we focus on trying to get the state courts to use their rules for moving cases along, that is, to put a halt to continuances. If this were done we could save a significant amount of money which could then be passed on to the various insurance communities in the form of rate reductions or rate moderations.

Let us now review the kinds of malpractice reforms that are traditionally mentioned. I will use four measures to evaluate these reforms: (1) frequency: how many claims are being brought; (2)

severity: what does it cost to pay them; (3) efficiency; and (4) predictability. With regard to frequency, contingency fees are an issue: most people think contingency fees stop unnecessary claims and also some that are warranted. In Pennsylvania it is unlikely that we will move to a contingency fee limitation in medical malpractice because our Supreme Court appears to have said that that would violate constitutional provisions.

As the system now exists in Pennsylvania, generally, there is no provision for attorneys' fees to be paid to the winner of a lawsuit by the losing party. Florida experimented with changing this system to create such a requirement. In Florida a judge does not have to make the losing party pay if the court deems them to be indigent. Insurance companies are rarely indigent; but the judges in these trials are likely to say that the plaintiffs might be, so the insurance companies are paying when they lose but not necessarily collecting when they win.

Then we looked at some changes that probably will be suggested in Pennsylvania. One of them was modeled after Federal Rule 11, which requires that the plaintiff and his or her attorney certify that they really have thought about the case and that it is a reasonable case to bring. According to this rule there are penalties if the court later decides that due consideration was not given to this issue. We looked at the possibility of requiring that once a complaint is filed, usually after some discovery although not always, the plaintiff will be required to obtain a preliminary analysis by an expert indicating that there is a cause of action in the situation. This is not a drastic change in the system, but it stands a chance of weeding out some unworthy cases. We also looked at trying to get an early exchange of experts' reports. If we get the reports early, find out what the theories are, and see if there is support, we can move the cases along with greater efficiency. We looked at the collateral source rule, which says that even if the plaintiff has been reimbursed by some other collateral source — for instance, had medical bills paid by a health insurer — the bills are presented to the jury, but not the fact that they have been paid. There are sound public policy reasons for this. We, however, view this practice as an unwarranted duplication of payment. Its effect is to encourage the plaintiff's bar to request greater contingency fees, in the knowledge that if the plaintiff wins he or she will collect twice. And therefore, that finances the 60 percent of claims which are brought, in our experience, that are ultimately closed "no pay." More claims than

not, in PMSLIC's experience, are closed without payment to the plaintiff. However, they are not closed without expense, and they are closed with an average expense of $7,000 dollars. Over time, this has cost PMSLIC almost $33 million. Now, we have collected a lot more than that, but it is a large amount of money for cases that are going to be closed no pay.

We also look at expert qualifications. Does the plaintiff have an expert who really knows his or her field, and do we? Have we given proper thought to the case before we go to trial? If we could establish what are the appropriate qualifications for an expert, maybe we could weed out some of the cases that are just riding into the courts on sympathy.

The next measure I applied to reform is severity. This encompassed some traditional tort reforms, particularly the issue of caps on damages. The Pennsylvania constitution makes caps on damages in malpractice cases unlikely — not impossible. Caps have been imposed in no-fault automobile insurance cases. Caps are not being proposed by the medical community at this time. Another issue is structured awards: future damages should be paid as they are needed. If the plaintiff dies, let us make proper accommodations for the dependents of the plaintiff, but we should stop the rest of the payments. We should not make a windfall payment to the claimants' family or friends.

As regards joint and several liability, we feel with respect to non-economic damages, pain and suffering, and the like, that those who are only modestly liable should pay only their share. The reform of the collateral source rule discussed earlier will also affect this question of severity of damages if, as I suggested, we reduced the verdict by the amount the plaintiff has already been reimbursed.

My next concern is informed consent. I hate even to talk about that doctrine as it exists in Pennsylvania right now. It leads to a giveaway, and we would like to see this situation modified to get it back to something reasonable.

Finally, punitive damages are much more effective as a force for inducing settlement in medical malpractice cases (because you cannot insure a punitive exposure) than they are as an actual payment made to a plaintiff. Let us separate out punitive damages and let us put some limits on when they are appropriate. Furthermore, we should have a determination that punitive damages are appropriate before the jury is presented with information about punitive damages expenses and the financial condition of the physician.

What we would like to see in terms of predictability and efficiency is revision of some of the court procedures. This process is, we recognize, fraught with danger because of the separation of powers. But if we could persuade the courts, through legislation or some other means, to speed up the process for exchanging experts' reports, for completing discovery, and for moving the case to trial or settlement, that would be good for everybody across the board. A statute of limitations reform would also help. We would suggest that cases brought more than four years after the treatment was provided be barred, with the exception of suits relating to minors, foreign objects that have been retained in the body, and fraud.

We need to take advantage of the current situation, when the system is not in crisis, for all parties to review the issues so that we move forward with meaningful reform. Thank you.

Richard Baron: I want to speak today as a practicing doctor, someone who spends the bulk of his time seeing patients; the other things that I do really inform that, more than the other way around. I am not going to offer you a prescription; as a practicing doctor, I have to be able to tolerate broken things. I will be talking about some current dilemmas of conception: limitations in the present way we think about malpractice and the ways in which they are not really helpful to those of us who try to practice medicine. I plan to suggest some directions that have been helpful to me in looking at malpractice. I will mention three cases from my practice just briefly to set up some parameters of the discussion for me.

The first case involved a young woman who came to my office with abdominal pain and bowel disturbances. I spent some time with her and my differential diagnosis was that her complaints were either stress related or that she possibly had inflammatory bowel disease. I opted for the stress related diagnosis and suggested that she seek counseling, which is not a suggestion that is always well taken by patients. We discussed my suggestion at some length, and I put it in mind to follow up on this patient. A couple of weeks later I called up to see whether she had sought counseling. She had not; she had sought a gastroenterologist who had made the diagnosis of inflammatory bowel disease. In fact she had had a good part of her small bowel resected a couple of days before I called. So as a practitioner this is one case that still troubles me and I wonder how I should think about my actions in that situation.

The second case that concerns me is in some ways less complex, but still more troubling. It is that of a patient whom I treated in another state when I first went into practice. The patient was hospitalized with diabetes and a high fever. I believed that she did not have a bacterial infection and made the decision not to treat her with antibiotics. As we were trying to figure out what was happening some of her cultures came back positive, and by the time we started the antibiotic treatment she was in shock. Ultimately she died. No litigation arose from this case, but I found myself thinking about it when Charles Bosk, during the discussion period, quoted the statement "I realized that I could not put my mistakes behind me and continue practicing; I wondered how other people did it." Well, those of us who practice medicine sometimes make mistakes, and if we are going to devote a life to practice I think we have to give serious thought as to how doctors can deal with the fact that doctors are not always going to get it right.

The third case I would like to discuss involved a patient who had very complicated medical problems. Even when we found out what were the causes of them, we were not really able to help him very much, and he wound up being significantly impaired. Early on in my treatment of this man I received a communication from his lawyer asking who my malpractice company was, which I understand from my malpractice company is the first step in what will eventually become a lawsuit. And interestingly to me, the patient continued under my care for six months, and also through two other lawyers, who both eventually asked about the patient's records. Finally, at the end of the six months, I said to the man, "I do not want to play any games here — I get these letters from your lawyers asking about my malpractice company. Are you planning to sue me? Do you not like the care you have received? You continue to come here, you must think I have something to offer you, because there are lots of other doctors in Philadelphia. I really want to know what is going on." And the man said, "You know that I have a lot of problems at the moment. I cannot work. I cannot pay my bills. I am not going to make any commitments to you until I talk to my lawyer and find out what my options are. I really have to look at all this because I have got a problem and I have got to solve it and I am not going to deal with your interests in this problem until I have dealt with my interests in this problem." I think this case illustrates that we have to keep in mind the predicament of people

who are injured very seriously as we talk about the question of malpractice.

Some of the problems I find with the current paradigm stem from the equation of mistake and negligence. If you look at the two poles that Charles Bosk talked about, we have negligence and we have injury or damages. For a doctor, negligence may be more happily conceived of as mistake, but it is a static event: as we usually think about it, it is something that happens at a particular moment in time. There is no appreciation of the uncertainty involved in medical decision-making. There is no appreciation of things unfolding in time in the concept of negligence. And as Sarah Lawhorne said, we are not supposed to use future knowledge as we look back, but the case would not be in court if we did not have future knowledge. This is the first problem I have with negligence; it is static in a way that is not helpful to those of us who have to make decisions. There is also the issue of an equivalence between sickness, injury, and disease and the concept of damages. This equivalence implies that a bad outcome is somebody's responsibility. Such a conceptualization is, I think, a kind of dark side of the medical accomplishment and progress that we have seen. As doctors are able to do more and more wonderful things, raise people's expectations, take on the mantle of technology, and live in a world where more and more things are controlled, it begins to seem that when bad things happen it has to be someone's fault. In this world I think that we no longer recognize any concept of Providence, of randomness, of God, if you will — of any actor other than the human actors on the scene. My family and I have been fortunate enough to vacation on Nantucket for the past few summers. To get there you have to make ferry reservations six months in advance and you have to be at Hyannis, Massachusetts, at 9:15 on a Saturday morning. It is a major accomplishment to get two kids and a car full of stuff to Hyannis, Massachusetts. And I assure you that when we get there we do not say, "thanks to the goodness of God we have arrived in Hyannis." There was a time and a place when people would say that. Today, we say, "aren't we terrific, didn't we dope out I-95 just great, there is no traffic at 3:00 a.m. when you go through New London." And I think that the extent to which everything in our lives is controlled, everything is made to happen, as the result of a human action, leads us to the conclusion that everything is either your fault or my fault. I take care of a lot of elderly people, and one of the characteristic hallucinations of people with

Alzheimer's disease, or what we now call senile dementia of the Alzheimer's type, is paranoia, and they often accuse their family members of stealing their possessions. It is one of the things that families complain most bitterly about: "I have turned my life upside down to take care of her and now she says I took her watch. Doctor, I just cannot believe she is saying things like that to me — how could she believe that of me?" And the best explanation I have ever read for this is that the woman has a memory deficit, and when she cannot find her watch she has two choices: either she forgot where she put her watch, or somebody took it. What is the healthy mind's response? Somebody took it, because I cannot be going crazy, I cannot be in so bad a state that I do not know where my watch is. And to the extent that this is a sort of fundamental human reaction to loss, difficulty, or distress, I think that we have to cope with it too when we think about malpractice.

We need to ask ourselves the question, how do people who actually practice medicine cope with a paradigm like this? I think that Charles Bosk's comments this morning about the way that doctors make patients invisible, make their suffering statistical, is very helpful. Doctors do put some distance between what is happening to the patients and what is happening to themselves. They do in some ways make patients strangers. They also view many patient's conditions as the patient's own fault. The patient, for example, was the one who was smoking the cigarettes, the doctor did not give him lung cancer. This is a game that doctors almost have to play. But I do not think it is in anybody's interest to play that game, and the more that the system makes us do so, the worse off we are. One of my favorite ways in which doctors deal with bad results is from the position of high authority. I will never forget an article in the *New England Journal of Medicine* published by a group of Harvard surgeons who had removed a patient's pancreas after a biopsy suggested that the patient had pancreatic cancer. As it turned out, the patient did not have cancer after all. The particular biopsy technique used in the case was limited in the resolution it might achieve. They published the case in the *New England Journal of Medicine* to alert everybody that they should not rely on this biopsy technique, and I thought, you know, only Harvard could put this in the *New England Journal of Medicine* and say, hey, we are going to publish our experience of taking out a pancreas that should not have been taken out.

And of course the other thing that doctors do to cope is they leave — they leave like crazy. They leave practice, they leave direct patient care. They become strangers because that is one of the ways doctors have to protect themselves from some of the rigors of this sort of practice. Now I do not want to paint a completely bleak picture — I have not left practice and I do not expect to anytime soon. I want to make references to two paradigms that I found helpful. The first is by a doctor named David Hilfiker, who has written a book called *Facing Our Mistakes*. Hilfiker is a very thoughtful, caring doctor who talks about the basic cultural dynamic of forgiveness and how important it is in human interchange. Sometimes you do something wrong, and when you do, one of the things you want is for someone to give you absolution; we keep coming back to these religious metaphors which I think make all of us uncomfortable, but there is something in them that is at least sympathetic to the experience of practice. We have somehow to develop an environment in which people who are on the line making decisions can cope directly with what it is to make mistakes, and with the people whom they may or may not have injured. At least there should be some sort of dialogue.

The other source that I have found really helpful is by a woman named Marianne Paget who has written a book called *The Unity of Mistake: A Phenomenologic Interpretation of Medical Practice*. She talks about how nobody ever makes a mistake because if at the time you did it you thought it was wrong, you would not have done it. So you only do a wrong action when it unfolds in time as a wrong action. She thinks we ought to be using words like actions going wrong, actions going bad, things turning away from a true and intended course. Any action involves risk, and in her book Paget quotes Karl Wallenda of the Flying Wallendas, who says "the wire is life, the rest is waiting." For those of us who are out there walking that wire, there are real dilemmas. We need models to help us understand how we make choices and what happens when we do not make those choices correctly.

As to a system of reforms, my expertise pales in comparison to that of other members of this panel, but I do think that we need to disentangle fault and injury. To the extent that one of my biggest goals as a doctor is to help people who are injured or unwell, I want a social system that will separate these. I do not think that a system designed to help patients who have been injured will necessarily be the best system to identify doctors who are not good. Nor will the

system that identifies bad doctors be good at helping patients who have problems, whatever the cause of those problems. I think we need to think in terms of quality improvement, rather than quality assurance, that doctors ought to be always trying to do better without worrying about setting standards where you shoot the people who do not meet them. I think that individual cases may not fall well into either — lawyers say that hard cases make bad law, and I am not sure that tough medical cases are the best way to judge doctors. We need some sort of social support system for those who are impaired by illness. To the extent that I do have any prescription, it does resonate with what David Rothman said about suing strangers: the wisest advice I ever heard any doctor offer about malpractice was that of the Chairman of Family Medicine in Florida, a man named Gayle Stevens. He tells all his residents to take a toenail clipper with them on rounds, and to clip their patients' toenails, because, he says, if you clip someone's toenails, they will never sue you. Thank you.

Walter J. Lear: As a healthy, white, male, middle-class professional it would be presumptuous to assert that I represent patient culture or the consumer movement on this panel. Nonetheless, I did agree that the panel would benefit from including someone like myself who has a broad perspective, someone who was not engrossed in the day-to-day world of clinicians or of lawyers or of insurance company officials. So, in contrast to the other panelists, my knowledge of the medical malpractice insurance issue is limited, derived from a selective literature review. On the other hand, my knowledge of the health field is derived from over 30 years' experience as a health services administrator with a major and continuing commitment to the public interest generally, and to people's health rights in particular, and a subsequent 10 years as a historian of American health politics.

In preparing these comments I first tried to figure out what this conference was about. I concluded it is not about much that is relative to the real troubles of America's health care non-system. The starting point for this judgment is two financial figures which most of you know well but which were new to me. The first figure is the dollar amount physicians spend on malpractice insurance premiums expressed as a percentage of the average physician's gross income. This was 4.4 percent in 1976, dropped to 3.2 percent in 1982, and rose again to 5.6 percent in 1988. To convert this to a

percentage of average physicians' expenses, my guess would be to double the figure — in other words, malpractice insurance premiums may account for about 10 percent of the average physician's expenses for practicing medicine. The second figure is the portion of the costs for physician services accounted for by malpractice insurance premiums, settlements, and defensive medicine; according to the study most often quoted, this is about 15 percent. If this amount, some $12 to $15 billion, is compared to the total cost for health care, $500 billion or so dollars, the medical malpractice insurance issue accounts for less that 5 percent of the total.

But my judgment about the intrinsic insignificance of the medical malpractice insurance issue is not really based on these financial characteristics. It is based on recognizing, as I am sure everyone recognizes, that the American health care non-system is in deep trouble; that there are a multitude of serious and interconnected problems of access, quality, delivery arrangements, financing, governance, and basic values. There is no need in these brief comments for a systematic and detailed account of such well-documented and extensively discussed problems. Instead, I will only comment about several issues that most closely relate to medical malpractice and medical malpractice insurance.

Starting from the most narrow focus, the significant issue, at least from the public's point of view, is not malpractice insurance, but malpractice. And malpractice takes us directly to the evaluation and improvement of the methods for physician discipline and quality assurance.

Medical malpractice has two distinct aspects suggesting quite different reforms or improvements. First there are the "bad apples." Claims studies clearly show that a very small percentage of physicians account for a very large percentage of malpractice losses. In other words, the great majority of physicians have never been sued for malpractice and, of the small number that have been, less than half are found guilty. However, in the past nothing much has happened to the guilty ones. The medical profession through its membership societies, hospital staffs, and state licensing boards has copped out of its disciplinary responsibilities and has allowed the "bad apples" to continue in practice, to injure, and to kill people.

A consultant's report prepared for the Pennsylvania Medical Society recommends that physicians who over a 10-year period have had three or more loss claims requiring compensation in excess of $200,000 should have their licenses suspended for six months.

During this time their qualifications would be reviewed and the need for additional disciplinary measures, if any, would be determined. This seems to be a most sensible and an essential first step. But a major, well-identified weakness in present physician disciplinary efforts, and certainly in any strengthened efforts of the kind suggested in the Pennsylvania report and by the American Medical Association (AMA), is the gross underfunding and understaffing of the state medical licensure boards. Licensure fees should be increased substantially and the increased income used for more and better staff to get rid of the "bad apples."

Perhaps more important than the "bad apples," and much more difficult to eliminate, is the widespread practice by presumably competent physicians of unnecessary surgery, medications, and other treatments. For example, a 1983 report found that in the three-and-a-third million patient visits for the common cold, antibiotics were prescribed in 51 percent — hundreds of thousands of prescriptions, costing over $15 million, for such ineffective and potentially dangerous drugs as Lincocin, tetracyclines, and Chloramphenicol. Another example: a major Congressional investigation in the mid-1970s estimated that each year two-and-a-half million unnecessary operations were performed resulting in over 11,000 deaths. Particularly notorious are the huge numbers of unnecessary hysterectomies and caesarean sections (at least half of all those performed in each case). Many other studies of negligence and iatrogenic injury could be cited.

The medical profession is replete with excuses for not dealing with this problem. More physician education may eliminate a few instances of genuine ignorance, but most of the physicians who do unnecessary things to patients are competently trained — obviously other factors are involved in this type of malpractice.

A principal recommended answer, logical but improbable, is the educated and assertive consumer. The women's health movement has shown how to accomplish this; it has also shown that this cannot be done for all patients across the board when the health field's leadership does not want educated and assertive consumers. Such opposition is clear from the nation's experiences during the past several decades with "consumer participation" in health services planning, governance, and other presumably patient-empowering efforts. Patients will not be empowered as long as they as nonpatients — that is, as the general public — have no responsibility for the governance of health insurance organizations, hospitals, and

physician services and as long as major segments of the health field are directly motivated by profit-making and the rest of the field is structured and managed as an industry with primary emphasis on competition and cost controls. In other words, expanded and well-designed education of both recipients and providers of health services is undeniably necessary for real improvement in the quality of care, but it will not be conducted until the service tradition is restored as the dominant value in the health field and until a democratic and knowledgeable governance is in place to undertake such obvious quality improvement efforts.

The conference literature requests consideration of doctor-patient conflict and reforms for adjudicating such conflict. In an environment where doctors are allowed to get away with murder figuratively and literally, patients, in my opinion, are entitled to substantial anxiety if not hostility; in fact, not to be skeptical of what the doctors want to do, and do, may be foolish. This tension cannot be ameliorated by superficial reforms. Rather, if the people control the health care system, identify with it, feel that it is their health care system, then the need for an adversarial relationship between doctor and patient largely disappears.

The current domination of the health field by financial, non-humanitarian values also has a very detrimental effect on conscientious physicians, particularly the younger physicians who have not lost their social consciences. Quality of care is directly and indirectly undermined. This is an issue which cries out for major attention and which appropriate bodies of the medical profession might well address with as much resolve as they devote to the medical malpractice insurance problem.

The high rate of malpractice suits against obstetricians and the consequent high cost of malpractice insurance for them has undoubtedly contributed to decreased availability of good maternity services. The solution to this problem will, however, not be found in malpractice insurance reforms but rather in a rational, nation-wide organization of maternity services, an expansion of the current Federal Title V Maternity and Child Health Services Program. Of course, that is unlikely for the same reasons that I summarized in my earlier comments about "patient empowerment."

My final comment concerns the consumer's real experience with medical malpractice law. In contrast to the much publicized and loudly decried — but relatively few — high awards are the generally inadequate payments made to patients when awards are

made and the small number of indefensible instances of negligence that do result in a suit. One authority on the statistical aspects of the subject, Patricia M. Danzon, states that in the mid-1970s "at most, one-in-ten incidents of malpractice gave rise to a claim." The mammoth and definitive Harvard Medical Practice Study in reviewing 30,000 New York State hospital records, found an adverse event rate of 3.7 percent and a negligent adverse event rate of 1 percent (about 27,000 negligent adverse events estimated for 1984) while "the risk of suit for a negligent medical injury is two percent." Stated another way, this study shows that "for every eight patients who suffered an injury from negligence, only one filed a malpractice claim, and for every sixteen patients who experienced injuries from negligence, only one received compensation." With regard to the size of awards, the General Accounting Office in its 1987 report states that "median payments for patients with economic losses of $100,000 or more were less than the [actual] economic losses."

Sylvia Law, a consumer-oriented professor at New York University Law School, has thoroughly reviewed the range of medical malpractice law reforms recently enacted or proposed; she concludes that "medical malpractice is largely irrelevant to the problems confronting consumers of medical care . . . . Few malpractice reforms even pretend to address the problems of unreasonably dangerous medical care or injured patients' medical and financial needs. Instead, reform is typically designed simply to reduce malpractice premiums [and commonly] limit patient rights that had grown over time. Reform efforts that see reduced premiums as the 'bottom line' will almost inevitably make things worse for consumers." *

I am saddened to see so much talent, energy, and money devoted to the medical malpractice insurance tempest in a teapot, when many people, middle income as well as low income, are having a difficult time getting a decent serving while many others do not even reach the table. Clearly the tea drinkers have sufficient wealth and status to demand and receive a disproportionate amount of attention. This seems to me just another example of the inability of the health field's present leadership to deal with or even grasp anything beyond its most immediate and short-range financial interests. As such it underscores the need for fundamental reform of the health field, particularly of the health care non-system, if the people

are to obtain the maximum benefit possible from today's art and science of health care. Thank you.

*See Suggested Reading List (pp. 305–306) for references on the information cited above.

James J. McCabe: Many of my points have already been advanced by Sarah Lawhorne and Walter Lear, and I was particularly impressed with the latter's observation that from the standpoint of a public health physician, the so-called medical malpractice crisis is a tempest in a teapot. It is not an observation I feel comfortable accepting and internalizing in the College environment, which is largely populated by physicians. But as I have looked at the phenomenology of this interesting area of society, I have tried to put myself in the role of a lawyer to whom the medical establishment came for advice, with the complaint that they have a malignant member and they would like me to see that it is legally amputated. The malignant member is of course the tort system. The medical establishment would say that it is driving them crazy and must go, that it is a fatal affliction. I would begin my advice to physicians by telling them that before I performed surgery I would want an informed consent from my new client. As you all know, in order to get an informed consent, it is necessary that a physician or a lawyer outline to the patient or the client the nature of the therapy or procedure that is to be performed, the side effects, the hazards, the downside risks of that kind of procedure, and also the non-invasive alternatives that might be less drastic or less dangerous to the patient or client. Bearing in mind also what the Hippocratic Oath tells us, "Do no harm," which I think is good advice for legal clients as well, I would set out to find what the facts were, and to find whether there really is a malignant disease process going on, or whether the client who has approached me has really got something that, while burdensome and annoying, is not necessarily fatal, and perhaps ought not to receive the kind of drastic procedure or therapy that the client requests.

What are the facts: Walter Lear alluded to many that interested me as I was preparing for this talk; the fact that 5.6 percent of doctors' income goes to the purchase of malpractice insurance is a very significant starting point. And I recall that last year PMSLIC in a news release of September 1990 published in the *Philadelphia Inquirer* stated that rates were dropping because of the excellent

experience PMSLIC was enjoying, due to the improvement in the way cases were being handled, and at least at that time, premiums were going down, so that the percentage of income expended may have been even further reduced. I am aware as well of the statistics that tell us that physician income is increasing. I am also touched by the question of what one speaker referred to as paranoia, although I prefer to think of it as over-reaction. I was very interested by the article describing malpractice research supported by the Robert Wood Johnson Foundation distributed to panelists and conference participants.* I strongly recommend it as one of the best overviews of the phenomenon of the medical malpractice issue, its causes, and its possible solutions, that I have ever read. One of the studies included in this article suggests that doctors who were asked in a scientific fashion what their perception of the malpractice problem was, and what kind of conduct was likely to bring a malpractice suit, over-reacted to the tune of 250–300 percent. This study confirms my own experience representing hundreds of physicians over the years: that the extent of the medical malpractice crisis is greatly overestimated.

When we try to assess the impact of medical malpractice, we are talking about a health care delivery system that costs the people of the United States something like 12 percent of the Gross National Product — $765 billion a year. That degree of activity in any industry or enterprise is bound to result in considerable litigation. And I do not think it is very surprising to learn that the AMA tells us that, over and above the $5.6 billion spent on malpractice insurance, a further $15 billion of additional treatments are rendered as a result of defensive medicine. I suggest that a lot of that defensive medicine is a result of the tendency to over react that I have observed. Perhaps one way to change the perception is for the AMA and others to promulgate more carefully the information that the doctor in court is not as helpless or as hopeless as I think the American public and most physicians think the doctor is. The Robert Wood Johnson article also tells us, and again this is confirmed by my own statistics from practice, that of those cases tried in court that reach a verdict, roughly 85 percent of those verdicts are in favor of the doctor — something that surprises many people. Now I know that the majority of cases are settled out of court, and many of them for a very substantial amount. But nevertheless, the doctors' dilemma is not as bad as the doctors think it is, and doctors should be relieved to know that.

We have talked about a number of alternatives that might be useful in dealing with the malpractice situation, and I think that some of the solutions offered are not realizable: take, for instance, placing caps of $250,000 on non-economic loss (pain and suffering.) In my experience, and as Walter Lear confirmed, the median award does not even compensate for economic loss. The reason I found that the so-called pain and suffering compensation does not necessarily drive up the size of the award is that the economic damages are usually so shockingly large that the pain and suffering damages are not required to get the award up into the range of $10 to $15 million that the plaintiffs' lawyers are able to put up on the blackboard to impress the jury into giving a lot of money. Generally speaking, jurors discount those large numbers, but they still come in with very large awards.

The medical establishment is seeking relief in the courts and in the legislatures, and I am reminded of the writer who said "if there were a malevolent God, he would answer all our prayers." I fear that if the alleged panaceas sought by our medical friends were actually granted by the legislatures, many of them would not work. Take, for example, the question of the contingency fee. It has been my experience that the contingency fee does, in fact, act as a screening panel. Good, competent plaintiffs' lawyers tell me that they have certain running standards of sizes of cases that they will accept on a contingency fee basis in the medical field; two years ago the minimum was $250,000, and I dare say it is up to half a million today. So right at the outset you have a certain limitation of the quality of the lawyers who will be suing you by virtue of the contingency fee system. And I am not surprised by the Harvard study that tells us that only one out of every eight instances of negligent adverse results turn into claims, and only half of those are compensated. It has always been my impression that for the very small case, like the sprained ankle or the drug reaction where the patient loses only a week or so from work, or the minor scar, or the minor surgical procedure that may not have been necessary, where the damages are marginal, lawyers will not waste their time because they will not be compensated. I think the system as it is polices itself, and that it is right for the wrong reason or wrong for the right reason, however you want to look at it. I am not sure that by getting a limitation on contingency fees that the medical establishment will achieve any advance in malpractice settlement. What the legislature will have to do then is to set up a program for

those claimants who cannot get a lawyer because a lawyer is not going to take their case when there is no contingency fee available. We end up with a bureaucratic adjustment of these cases. And guess what: the state will pay the lawyer who will sue you or needle you to death, and the size of the irritant will be totally immaterial.

There are some other points that I would like to make. I agree with Sarah Lawhorne that there are some elements of malpractice that ought to be attacked either legislatively or in the courts. I think at this time we have gone as far as we can in the courts with Rule 238, which is the imposition of pre-judgment interest. Even though the Prothonotary of the Pennsylvania Supreme Court is in the room today, I must suggest to you that this Rule is a raw example of judicial fiat, of judicial legislation. The Supreme Court of Pennsylvania has declared that because insurance companies tend to hold on to their reserves, make interest on the money, and hence delay the day of claimants in court, there should be a method to encourage insurance companies to settle early. So the court has declared in Rule 238, a rule of procedure, that in a case where a plaintiff gets a judgment that is more than 120 percent of the offer, the plaintiff is entitled to pre-judgment interest, starting from the day the complaint is filed, at the amount of 10 percent per year. I was just consulted on a case that was tried in 1983, and there is an 80 percent interest on that judgment which was announced yesterday in a non-jury setting. And frankly, I think that is unfair. I have lost my challenges to it in court, but there is no reason that the legislature cannot tackle the issue and have the final say. I think it is something worth tinkering with, because it would protect not just the medical profession but anyone who is sued in court. The medical profession would be better off if it stopped singling itself out of the pack and instead joined with product manufacturers, lawyers, and other people who find themselves being sued for negligence. In numbers there is strength, and it would also prevent accusations of single purpose, special interest legislation.

Another area that requires addressing is the collateral source rule, as Sarah Lawhorne told us. The existence of collateral sources keeps many smaller cases out of the courts, because they provide compensation for medical bills, but the existence of them should definitely be brought to the attention of the jury and the judge when a major case is before the court. The court should take into consideration whether it is socially appropriate to give such a plaintiff a double dip, as it were, into the system.

The Pennsylvania case of *Kaczkowski v. Bolubasz* is also very instructive for future legislation.* This is a case which has enormously inflated permanent injury and death awards in Pennsylvania. Because of this case, as Sarah Lawhorne told you, the jury is given no limitations on reducing future lost earnings to present value. This situation has driven up by many multiples the awards in these kinds of cases.

I would finish my conversation with my client who comes to me requesting an amputation, by saying well, I have tested the systems, I have taken a history and done a physical examination, and I do not think you want an amputation. The amputation, this tort reform legislation or extreme social change, may do you more harm than good. Since you are improving, or at least stable, I would suggest we try some conservative modalities of treatment, of the types that I have just described, and take a couple of aspirins and we will talk about it in the morning. Thank you.

*See Suggested Reading List (pp. 305–306) for references on the information cited above.

Jan Cauffman: I want to start by saying that people enter the health care system, very simply, because they want to be cared for and made better. But some people are not leaving the system with those feelings. Sometimes they leave just feeling injured and sometimes they actually are injured. I am going to address the situations where people feel injured. I would like to start by defining care: care means responding to the experience of another. Patients experience fear, confusion, anger. They get overwhelmed by our crazy system, and what they seek from us as health care providers is direction, competent care, assistance, support, and respect while we treat and try to heal their bodies. The current problems as I see them involve the stranger at the bedside phenomenon which David Rothman described earlier. The erosion of trust, and the loss of faith in the therapeutic alliance between patients and doctors, plus unrealistic public expectations, are all symptoms of this problem of poor communication. So how do we attack this problem at its root? I have a proposal for three different levels of attack.

The first level is that of education. We need better training in the professional schools of medicine, nursing, physical therapy, pharmacy, for all of us, on how to deal with the daily counseling and needs for support of patients and families. We can teach people

how to deliver bad news with tact, compassion, and an element of hope, while offering realistic explanations of the physicians' human limits — those limits of uncertainty and time that Richard Baron described. I think when people hear these things as patients, they understand. I think that we can teach staff to distinguish between normal adjustment reactions to loss and change and symptoms of real problems such as lack of informed consent or unclear treatment goals. What I am not talking about is developing a smokescreen of nice guy clinicians who pacify irate patients and families, but of increasing the level of skill of all of our practitioners, so that we respond as well to tearful, frightened patients as we do to low hemoglobin levels. People argue that you cannot teach people to be humanitarians, that they either feel empathy with patients or they do not, but there is a considerable body of evidence that people can be taught to be more compassionate. Eric Cassell at Cornell University Medical School has worked in this area and has written several excellent books on talking with patients. He has been able to show specifically that if you can point out to physicians and nurses what feelings and reactions in patients they need to look out for, they do learn to recognize them, and they can respond to their patients better. I find it a sad commentary, however, from my own experience teaching medical students at Osteopathic Medical Center, that the most misspelled word in the papers they write for me is "rapport."

My second recommendation is to increase the utilization of people like nurse counsellors and psychiatric liaison nurses in the health care system. Other people in the system, patient representatives, social workers, clergy, also can play an important part, but in my remarks I will concentrate on the role of the nurse. Research has shown that nurses are much trusted by the public, more than many other professionals, and that the role of facilitator, counsellor, and educator has always been within the scope of nursing practice. Nurses are easily accessible, they are already in the system, they can be consulted by anyone — patients, families, or physicians. I had the role of nurse counsellor at Osteopathic for a while, and I think it is a very successful model. Nurse counsellors can provide more ongoing support for patients in the more complex situations, such as terminal illness, difficulty coping in spite of first line staff efforts, and complicated family dynamics. The nurse counsellor should ideally also be an expert in symptom and pain management, because these things really affect the ability of the patient to be truly autono-

mous. The nurse counsellor can offer the opportunity for patients to ventilate safely their anger and frustration, and to ask questions. The nurse counsellor can also empower patients by helping them phrase questions to their doctors. Then, when the patient asks the doctor something, it does not sound like an interrogation that questions the doctor's competence. This makes the physician defensive. People can be taught to ask questions that will merely elicit the information they need to help them make decisions for themselves. Nurse counsellors can also promote and facilitate communications between patients and doctors so that mutual understanding can be achieved. Oftentimes I think physicians have the experience of critical information about the patient having been revealed to the nurse rather than to the physician. Providing care and counselling to families as they struggle with changes in the patient's condition is another part of the nurse counsellor's role. Assisting the hospital staff when they are caught in the midst of decisions and uncertainties by providing a person to go and talk to is another contribution.

In these ways many potentially volatile situations can be defused before they reach the boiling point and communication breaks down completely — such as cases where the patient signs out "against medical advice," or where the patient feels so impotent that they threaten to sue in an attempt to regain some sense of control.

My third recommendation is to use ethics committees which can be consulted when the problems confronting patients and doctors reach the level of a major ethical dilemma. If we have not been able to resolve problems with our well educated staff and their communication skills, or with the nurse counsellors' special skills, then the ethics committee has a role. Again this is an alternative to a legal battle. The roles of ethics committees are threefold: education, policy and guideline development, and consultation. Like nurse counsellors and skilled clinicians, ethics committees can help facilitate communication with patients and resolve disagreements that are based on misunderstandings of facts and principles. They can restore a sense of shared responsibility in the decision making process to patients and families, and can educate not only themselves but the larger hospital and lay communities as well. They can also be a resource for professionals.

Policies and guidelines developed by ethics committees offer standards of care that have been reviewed by an interdisciplinary group before approval and implementation. Consultation, however, is the key function. Ethics committees do not make medical deci-

sions, they merely make recommendations, which the physician, as the ultimate decision maker, can choose to agree with or put aside. The ethics committee can offer a range of choices and outline the advantages and disadvantages of those alternatives, and they can clarify the rights of patients, families, and health team members, while discussing issues and mediating conflict situations.

Ethics committees are very young — they are only about 10 years old — and we do need research to prove the effectiveness of most of the ideas I am suggesting, but since we are brain-storming I throw them out for your consideration. A study by Stuart Younger, et al., was published in *Law, Medicine, & Health Care* in February 1984 about patients' attitudes toward hospital ethics committees.* Seventy-six percent thought that ethics committees would be useful, and that they should provide consultation, facilitate communication, and offer advice. Forty-three percent of patients thought that ethics committees should be involved when any disagreement or uncertainty exists, and 38 percent thought that ethics committees should be involved in all life and death decisions. Most patients and families, however, are unaware of the existence of ethics committees, so the committees still remain very much under the control of the professionals. But I think this is easily remedied. Part of what may occur as a result of the patient self-determination act which goes into effect in December of this year will be that upon admission patients will be educated about the hospitals' policies, about their right to have a living will, and their right to refuse treatment. I think informing patients at the outset about ethics committees, how to call them and when to call them, is a good way to educate people as they come into the system. The President's Commission Reports also recommended ethics committees as a supportive device. The question remains, however, as to whether ethics committees serve patients or institutions, and that can be a critical question. A large percentage of the cases that we currently handle on ethics committees tend to be related to the discontinuation of treatments, do not resuscitate orders, and patients who are incapable of decisions, but it would seem to be possible to widen the scope of reference. The goal of ethics committees, as described by Ruth Macklin, is to search for a solution which is morally sound and puts the patients' well-being and rights above all other concerns. Because the current problems in our health care system are so complex, a multi-faceted

approach is going to be necessary. The three elements I have described, I believe, should be part of that approach. Thank you.

*See Suggested Reading List (pp. 305–306) for references on the information cited above.

James Greenwood: I am not an attorney; nor have I been a prime sponsor of legislation to reform the medical malpractice laws in Pennsylvania. I have expressed the opinion that I would vote for reasonable malpractice insurance reform legislation, so, in my views, I tilt in that direction. I should also note that over the course of 11 years in politics I have received significant contributions from the medical association as well as from the trial lawyers. The trial lawyers have been trailing off a little bit in contributions because of my votes on automobile insurance and my position on tort reform for the manufacturing sector. These facts say a little about who I am and set my biases before you.

I believe that there is nothing wrong in using the tort system to resolve disputes between physicians and patients. I think that, in fact, it is arguably the only rational way to provide justice to both parties. I think ideally that the tort system can and should adequately compensate legitimate victims for real losses; can and should adequately compensate attorneys for their expertise and their time and effort. The tort system could and should adequately protect physicians from false or exorbitant claims, and it could and should play an important role in assuring the quality of care and insuring that physicians and other health care providers exercise due caution with regard to their judgments and their practices.

The Pennsylvania legislature passed a law in 1975, as is well known, that required physicians to carry malpractice insurance, and it also set up a system of mandatory arbitration for claims. The Supreme Court five years later repealed the arbitration system, and we have lived with the results ever since. There are unintended results of our present system, I believe. Among them are awards that are unrelated to and that far exceed legitimate losses; attorneys' fees that are unrelated to and that far exceed their needs for legitimate compensation. False claims are made against physicians, and medicine is practiced because it is legally indicated and not because it is medically indicated. Some excessive costs are forwarded to the consumers. It is interesting that arguments have been made with

regard to what is the size of this problem: are the physicians overreacting here when, in fact, the cost of their insurance in premiums is only 5 percent of their gross income, and maybe 10 percent of their expenses. It is interesting to hear attorneys make that argument. It occurred to me while I was listening to James McCabe and Walter Lear that given the fact of the state of Pennsylvania's $2 billion budget deficit, that a way to resolve this deficit would be to put a 5 percent tax on legal fees. It is like saying we are only going to amputate five percent of your leg: if you could take only three percent off, I would rather you do that. So I think we do have a responsibility, regardless of the magnitude of the problem, to look reasonably at this system. If there is something wrong it should be fixed and that is part of my job as a public policy maker.

The problems in the system lie in the fact that it is not driven simply by humane considerations for making whole the injured party but is driven in large part by the profit motive. It becomes, therefore, the role of the state to place restraints on the profit taking in this business, because we cannot reasonably expect the legal profession to restrain itself in this regard. I do not think it is human nature for us to limit our profit taking as long as it is legal and it is available.

It was said earlier that maybe, if we are trying to develop a consensus between doctors and lawyers, something that has heretofore eluded us, the way to do it would be to point to me and say "it is the government's fault, the legislature's fault" and the two combatants can agree and come after me. I think this presumes that the legislature has a mind of its own, or that legislators have minds of their own, which is a generous description of us. In fact, the efforts to resolve this issue are driven by the combatants. It is quite frankly the contributions made through political action committees by the trial lawyers to legislators, by the medical society to legislators, by the insurance federation to legislators that tend to get in the way of our resolving the issue to the extent that it needs to be resolved.

How would I resolve it? I would look at those factors that cause the system to be driven by a profit motive rather than a need to compensate the patient. I would look seriously at and also support caps on punitive damages and caps on pain and suffering awards. If there is any consensus that has emerged from this panel today it is that collateral source rules constitute double dipping. We

have tried to move away from it in the automobile insurance area. I have not heard a rational argument for compensating the patient twice for a single injury. Joint and several liability, I think, is another reasonable area for our attention. The amount that an entity receives, be it a physician, a clinic, or a hospital, should have some relation to the amount of negligence and not merely the depth of the pocket. Those three items, not coincidentally I suppose, seem to be the top three items in President Bush's recent recommendations. If you want evidence that delving into this thicket is dangerous to your political health, there is no better evidence than President Bush sending Vice President Dan Quayle to deliver this message.

Will the legislature resolve this issue in the near future? Probably not. History is a good teacher, and we have gotten essentially nowhere in the last 11 years. My colleague in Harrisburg, Representative J. Scot Chadwick, introduced *the* bill on medical malpractice reform last session. He is an attorney, his father is a physician, his proposal was roundly supported by the medical community and despised by the legal community. It went nowhere. He is not going to reintroduce it because the doctors have decided to let a Democrat try since the Democrats control the house. The impediments to change are first and foremost the trial lawyers' money. They have more of it and give more of it in campaign contributions than anyone else does. I once computed, by the way, that if all the physicians in Pennsylvania gave five dollars more to their political action committees, they could beat the trial lawyers in contributions. Of course, the trial lawyers would then add 10 dollars to their contributions, but the overall total is certainly a factor. Another factor is that the key decision makers in the legislature tend to be attorneys aligned with the trial bar, and leaders of the judiciary committees tend to be so as well. The real impediment to change is that the leaders of the legislature are not only in charge of leading the legislative agenda, they are also in charge of raising money for their caucuses for re-election purposes. You do not get re-elected if the other side raises more money than you do. If the status quo is maintained, it is fairly safe to say that the trial lawyers and the medical society will continue to buy tickets to our fund raisers. If we change the status quo, it is likely that one or the other of the parties will stop attending, at least the fund raisers of the political party that leads the charge. It sounds like an awfully cynical thing to say, but it is descriptive of what happens in Harrisburg.

Another factor that impedes resolution of malpractice issues is that the medical community, the constituency that wants the change, is a relatively small constituency in numbers. If you look at automobile insurance reform, where basically we had the same contestants — the medical community, the insurance community and the trial bar — fighting in Harrisburg, you had a huge constituency in that practically every Pennsylvania voter has to buy automobile insurance. Most of them were very angry. But with all of that pressure on the legislature, we barely stumbled at long last into some kind of a resolution that may or may not help the situation. So with the public demanding reform in automobile insurance, with millions of Pennsylvanians demanding real reform, we got half-baked reform. You can imagine that with the relatively smaller community of physicians, spending very little of their time actually lobbying for change, there is not much political pressure to take action. When it comes to the medical community's abilities or tendencies to lobby versus that of the legal community, I have to say it is no contest. I do not know why, and there are exceptions, but physicians as a rule tend to be far less involved in the political processes in their communities. Probably if you asked ten lawyers who their senator is, eight or nine of them would get it right but only one or two physicians would answer that question correctly. I am sure that the physicians would tell you that it is because they are busier in their more noble profession, that they have less time for politics. For those physicians who would like to become more actively involved, I suggest that you stop relying on your medical society to do the work for you. Your lobbyists are fine in Harrisburg, but legislators are moved by a couple of things, and one of them is votes. When and if a group of five or six or ten or fifteen physicians come to visit or invite to dinner their local legislator, and demand change, they are much more likely to get it than if they only make their wishes known through the lobbyist that we see every day in Harrisburg. The lobbyist himself cannot exert much pressure one way or the other on us because he does not vote in our districts.

These are my comments, and just to respond to Sarah Lawhorne's suggestion, that perhaps what the legislature ought to do is influence the court system, I do not think we are the best ones to ask to do that — the courts do not listen to us. They really believe in the concept of separation of powers, and so do we. They tell us what to do all the time. They pass orders that the legislature will

fund them to the tune of $400 million, and we thumb our noses. We pass laws, and they thumb their noses back. If the bar association and medical community can achieve a consensus, they can obtain a response from the courts without the legislature's intervention. Thank you.

Closing Remarks

WILLIAM L. KISSICK
CLIFFORD GRAHAM

William L. Kissick: There are 66 registrants for this conference: 24 physicians and 13 lawyers or judges — I thought that was an appropriate ratio — 11 Ph.D.s, and 18 participants "unspecified," and therefore I assume presumably objective on the issue of medical malpractice. Now, numbers are important. There are 750,000 physicians in the United States and 1,500,000 lawyers. Each physician is responsible for supporting two lawyers. With 66 registrants and a conference lasting six hours, the conference represents approximately four hundred person-hours of deliberation. It is therefore extremely difficult, if not impossible, for me to summarize all that has been said in these remarks. So I will not attempt a review, but will rather "close" the conference by indicating some of my biases to join some of yours as you reflect back on this experience.

I have studied this exercise of closing for a number of years. I attended my first professional conference as a young physician in 1962, and the "close" was excellent. I studied the technique and have followed it ever since. The speaker began by saying that closing a conference is like being the chorus in Greek drama. You have the responsibility for identifying the protagonists, crystallizing the issues, forecasting the crises, but under no circumstances interfering with the action or influencing anybody's perception of the drama. I accepted this assignment to offer closing remarks for a very deliberate reason. I gave you a clue yesterday evening in my introduction of Eli Ginzberg. I suggested that had I been asked, I would have titled the conference "Law and Medicine: Two Cultures in Search of Common Ground," instead of "Seeking Common Ground: Law, Medicine, and Patient Care in the 1990s." I think the easiest way to explain why I would have chosen this title is to review my impression of the cultures of law and medicine.

The culture of the courtroom is known to many of you very well and feared by others. I was introduced to the courtroom as a second-year student at the Yale University School of Medicine. I was a freshman-year counsellor at Vanderbilt Hall, and my roommate was a second-year law student. This was an interesting point in each of our lives. In the medical school there were no grades,

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required attendance at classes, or exams. Everything rested on the National Boards in the spring of your second year. By mid-year I was beginning to panic, but my roommate, a second-year law student, was getting bored. The Yale law students, who receive what the late A. Bartlett Giamatti used to call a "first-rate writing education with a third-rate literature," are so bright that they learn it all the first year, and then the faculty have to try to keep them amused for a couple more years, with difficulty. My roommate and I, for comic relief, went to each other's classes. I went to law classes, mock trials, and moot courts. He went to clinico-pathologic conferences, to grand rounds, and to the wards. We each had a very interesting experience, and one thing we learned very quickly was that law and medicine are different cultures. They are so different that they even have distinctive conceptions of truth.

On today's panel we have three Harvard graduates. It is the oldest university in our country, and its motto is "Veritas" — Truth. At Yale I spent 12 years guided by the motto "Lux et Veritas" — Light and Truth — and I never cease to be amazed at those for whom truth alone is enough. I have learned that it takes a lot of Lux to search for the Veritas, because truth is elusive. And the separate cultures of law and medicine have distinctive truths. In medicine, if you satisfy Koch's postulates, or if you have a statistical significance with a P value of less than .001, it is true. The double helix is true — it has been with us since Adam and Eve. It took Watson and Crick to find it in 1953, but it has always existed. Legal proof is relative: if judicial procedure prevails, the rules of evidence are followed, and 12 of our peers vote yea, it is true. So here we have conflicting Veritas, which causes problems when we search for common ground.

Twelve vote yea — We the People — there they are. Eli Ginzberg pointed out that the founding fathers, working but 18 blocks from here, did a very interesting job in 1787, by crafting a form of government that is very frustrating. Winston Churchill said, "Democracy is the worst form of government except for every other form tried by man." Ginzberg implied last night that the health care system created in our democracy gives proof that we have achieved the worst. And our government does have a lot of interesting characteristics. When the Constitution was written, the average life expectancy was only 35 years. When Otto von Bismarck created social security in nineteenth-century Germany, the average life expectancy was 49 years, and he set the benefit at age sixty-five. Now that is

what I call brilliant politics. Wilbur Cohen did not predict the life tables when we created Medicare in 1965. We had no idea that a new beneficiary would have 21 years of eligibility on average. Last night Eli Ginzberg said that George Herbert Walker Bush (Yale, 1948) was not going to touch the problems of the health care system in 1992. Maybe in 1996.

The British parliamentary system is a different form of government. To tell you about this government, I am going to tell you about why I accepted the invitation to do the close. I had a trump card: Mr. Clifford Graham, Under Secretary for State, Department of Health, in Her Majesty's Government. He is also director of the Institute of Health, Kings College, London. Cliff Graham is a barrister at law as well as a senior civil servant. As lawyer and physician, working in the mother country and the colonies, for more than a decade the two of us have been searching for common ground. Looking for a sort of mid-Atlantic solution to health policy problems, we have been attempting to forge a system that utilizes the potential and talents of nurses, physicians, and other health professionals, while retaining the primacy of its raison d'être: caring for the patient. I have asked Cliff Graham to pick up at this point on common ground, guided by the words of Robert Burns, the Poet Laureate of Scotland: "Oh would some God, the giftie gie us, to see ourselves as others see us."

Clifford Graham: The recent election results at Monmouth, Wales, in which a Labor candidate was elected to what had been seen as a safe Tory seat, are being viewed as a sort of referendum on the British government's proposed changes to the National Health Service. These changes were essentially moving England toward the American model. One of the most predominant worries of people as they looked at the proposed changes was that somehow the British would get landed with the mess you have been talking about this afternoon. People are genuinely frightened about that possibility. As a lawyer I should not be too bothered, I suppose, but frankly I do not want the law to get any further into the health business than it has at the moment, and I will try and explain to you why I think this.

The first reason why I think we in Britain are not going to get into the mess that you in America are in and why things might change for you too is that we tend to trust the doctor. When the few arguments that occur between doctors and patients do arise it is the politicians who usually end up being blamed for not providing

the money to solve the problem. But we also trust the lawyer, and this trust has a thousand years of history behind it. We are currently reforming the British health care system, because like you, we do not think it is right as it is. Some of the elements of reform would reflect themselves in the courts if we were here, but they reflect themselves in the ballot box because we are there. But we are also currently changing the British legal system, much to the displeasure of the lawyers. The Lord High Chancellor, who comes from Scotland, is changing the law with the idea of preventing the kind of problems that are happening to you from occurring to us — to stop us from becoming too litigious.

We in Britain are not litigious — we have a solid base of law that we admire from afar, and we walk around the Inns of Court but we do not actually engage in as much litigation as you do. So I think if Americans are now looking to change things, and are looking for a view from outside, you might consider those two facts about the legal and medical professions in England. But if you are not keen to do that, you can look at the situation from an economic perspective. If the British spent as much on medical malpractice as Americans do, we could not afford medical advances nor the requirements for demographic change, which are significant items in our budget. They are very important to us, but we would wipe the possibility of them out if we engaged in as much litigation and added the costs of the administration that it would require. The moral of this story is that Britain, with no written constitution, with no code of law, with no digest of medical practice or clinical notes of guidance, is free to sail with the wind, and if we are on board the vessel perhaps we will sink, but we do have the flexibility of change.

The advice I would give to American physicians and lawyers as you think about changing things is to think about flexibility. The message I ought to give you is contained in a story about Christopher Columbus. He is alleged to have discovered America, but the trouble was, he did not know where he was going when he set out, he did not know where he was when he got there, he could not report where he had been when he got back, but he did it all using somebody else's money. Thank you.

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Compiled with the assistance of the conference participants, Julie Johnson, and Janet A. Tighe.

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Reviews

MIRKO D. GRMEK. *History of AIDS: Emergence and Origin of a Modern Pandemic.* Translated by Russell C. Maulitz and Jacalyn Duffin. 279 pp. Princeton, N.J.: Princeton University Press, 1991. Price $29.95.

Reviewed by ROB ROY MACGREGOR

Mirko D. Grmek, formerly professor of the history of medicine at the University of Zagreb, and currently teaching at the Sorbonne, has written a short history of the AIDS epidemic from an international perspective. Originally published in French in 1989, it has now been translated into English. Grmek's goal is stated in the introduction:

> In recounting the beginnings of this pandemic, in probing behind the scenes of official science, in explaining current research strategy and the vicissitudes of the struggle against an unexpected plague, and in reflecting on its biological and social causes, I hope not only to shed light on this problem for the contemporary reader, but to provide a testimony for the future historian (p. ix).

The book is divided into four parts. Part One covers the period from the first reported cases to 1984. It focuses on the unfolding insights into the disease gained primarily from epidemiological research in the American homosexual community, but also provides interesting information about early cases in Denmark, Italy, France, and other parts of Europe. By the end of 1984, the powerful tools of epidemiology had shown the disease to be associated with the "Four H's": homosexuals, heroin addicts, hemophiliacs, and Haitians.

Part Two deals with the laboratory effort to identify the suspected viral agent responsible for the lethal loss of immune competence which characterizes the victims of the Acquired Immunodeficiency Syndrome. The story is a fascinating blend of sophisticated virology, hunch playing, luck, and the unfortunate but almost inevitable controversy over primacy of discovery. It is told from a European perspective, and thereby provides valuable insights

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for the American reader. The section ends by emphasizing the importance of the development in 1985 of a reliable serological test for HIV infection, allowing for the discrimination of three clinical stages: asymptomatic, symptomatic, and AIDS.

Part Three, entitled "A Look Back," addresses the question of the origin of the epidemic, asking whether or not it is a "new" disease. This is the weakest and most speculative section of the book, as the author presents the argument that cases of AIDS can be found in the literature as far back as 1940! When he discusses the situation in Africa from the early 1960s, he treads on progressively firmer ground, and the reader will benefit from awareness of these epidemiological and case data.

Part Four continues the discussion of the origin and spread of HIV, touching on issues such as the simian immunodeficiency virus (SIV), the heterogeneity of HIV, attempts to trace the various retroviruses back to their points of origin, and the inevitable cultural and political biases which complicate such attempts. The book's last chapter makes dire predictions for the epidemic's impact on selected populations in Western Europe and on the general population of Africa and Central and South America. Nonetheless, the author points out that epidemics characteristically run predictable courses characterized by rapid expansion, saturation of eligible subjects, and adaptation between the epidemic organism and its target population. This profound insight deserved more development.

The book's greatest strength lies in the viewpoint of the author, whose impressive background in medical history and cosmopolitan European vantage point are particularly useful to the American reader. This is most evident in his treatment of the relationship and interactions between the French and American scientists involved in the discovery of HIV. The book also has several weaknesses, some mechanical and some substantive. Among the former, chapters headed by untranslated quotes in German, French, Latin, and so on, do little to inform the non-linguist. The footnotes required looking up the number in one appendix, which then referred the reader to another appendix for the full reference. The book's major substantive weakness lies in the author's failure to distinguish between well-founded scientific data and the more speculative information which is associated with issues such as the age and origin of the virus.

On the whole, the book is well-written, informative, and full

of useful information. I recommend it to anyone interested in the events surrounding the first ten years of the AIDS epidemic.

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MAXWELL M. WINTROBE. *Hematology, the Blossoming of a Science: A Story of Inspiration and Effort.* 564 pp. Philadelphia, Pa.: Lea & Febiger, 1985. Price $60.00.

Reviewed by DALE A. DOTTEN

For over 60 years, Maxwell Wintrobe was a dominant figure in hematology. A clinician, teacher, researcher, and writer, he was one of the political forces which shaped the era he termed the "Golden Age of Hematology." In the foreword to his book *Hematology, the Blossoming of a Science: A Story of Inspiration and Effort,* he states that this book can be considered to be the third part of a trilogy. His first book, *Clinical Hematology,* written in 1942 and now in its eighth edition, remains a major reference textbook. Pursuing his interests in the history of hematology, in 1980 he edited a second book, *Blood, Pure and Eloquent.* In this work, key individuals described the development of many of the important areas of hematology. *Hematology, the Blossoming of a Science,* his third and last book, was conceived in response to requests that he write his biography. He decided to include not only his own biography but, in abbreviated form, those of the major contributors to the progress of hematology during his career.

The book is organized into three parts: the history of hematology prior to his graduation from medicine, his biography, and finally, the biographies of his contemporaries.

The first section of the book, the history of hematology from antiquity to the 1920s, is a brief 64 pages which begins with a short history of the microscope, meanders through the early clinical contributions, advances in histology and pathology, and culminates with the story of pernicious anemia, since the influences of that group of researchers were to dominate his entire generation.

The second section of the book deals with Wintrobe's career. Beginning with his birth and medical education in Canada, he traces his progress through Tulane University, where he did epidemiologi-

cal studies on anemia, designed the Wintrobe hematocrit tube, and described the importance of red cell indices. His subsequent move to the Johns Hopkins University, where he noted the birefringence (ordering of the molecules) of sickle cells — the clue which led Linus Pauling to his first Nobel Prize — and his final move to Salt Lake City 1943 are well documented. In Utah, he and his group were, in addition to other areas, pioneers in chemotherapy, utilizing knowledge gained in the study of chemical warfare to treat Hodgkin's disease.

The third and largest section is devoted to the biographies of more than five hundred individuals whom Wintrobe felt had made significant contributions to hematology. Some of these biographies are first-hand recollections, and some sense of their personalities is captured. In other cases, however, the data has been gathered by writing to the individual concerned.

For me, this section of the book is the most interesting. Wintrobe has divided hematology into a number of areas, and his biographies are fitted into the appropriate areas. There is a sense of the flow of enthusiasm from the senior to the junior investigators, a sense of the structure upon which the good departments of hematology have been founded.

In summary, I enjoyed this book. Its major shortcoming is that its appeal is limited to hematologists, particularly the group trained by Wintrobe and his confrères, and to those interested in the history of hematology. For such individuals, Wintrobe offers an unique perspective on the unfolding of hematology in this century.

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DAVID I. GROVE. *A History of Human Helminthology.* 822 pp. Wallingford, Oxon, United Kingdom: C. A. B. International, 1990.

Reviewed by JOHN FARLEY

A History of Human Helminthology was clearly an enormous undertaking. David Grove, a physician from the department of microbiology and infectious diseases at the Queen Elizabeth Hospital in Woodville, South Australia, has gathered together an imposing list

of primary source material dealing with the most important human trematode, cestode, and nematode parasites: *Fasciola, Clonorchis, Paragonimus,* the schistomes, *Echinococcus, Taenia, Diphyllobothrium,* hookworm, *Ascaris,* the Guinea worm, *Trichinella,* filarial worms, and others. This material was then summarized sequentially, parasite by parasite, chapter by chapter, to give a narrative account of who discovered what and when, to which was added a forty-page biography of over one hundred helminthologists. There is no question that the author has done a marvelous job in what he set out to do. *A History of Human Helminthology,* Karl Enigk's *Geschichte der Helminthologie,* and B. H. Kean, Kenneth Mott, and Adair Russell's *Tropical Medicine and Parasitology* now provide three unsurpassed reference texts. But is this history? Has Grove, as the back-cover blurb states, put "the work of all those who have labored in the field of helminthology," into a "historical context"?

Historical context comes in many guises, but descriptions of what helminthologists discovered or wrote one hundred years ago cannot be counted among them. The scope of this book is indicated by the two indices: a person index and a subject index in which the huge majority of entries are limited to specific names, not concepts, not institutions, not historical events; nothing exists outside the narrative flow of helminthologists and their discoveries. Historical writing in the field is ignored. We read about hookworm, but there no reference to John Ettling's *The Germ of Laziness*; of onchocerciasis, but no reference to Gerald Hartwig and K. David Patterson's *Disease in African History*; of schistosomiasis, but no reference to F. R. Sandbach's "The History of Schistosomiasis Research," *Medical History,* 1976, *20*:259–275, or to his "Farewell to the God of Plague — the Control of Schistosomiasis in China," *Soc. Sci. Medicine,* 1977, *14*:27–33. Likewise Michael Worboy's work goes unmentioned. Surprisingly perhaps, he does refer to my own paper "Spontaneous Generation Controversy, 1700–1860: Origin of Parasitic Worms," in the *Journal of the History of Biology,* 1972, *5*:95–125, on the origin of parasitic worms not because I provided the framework for his second chapter on the origin of worms (which I clearly did), but because he used my translations of some of the passages he quotes which happened to correspond to the ones I selected to use. I must say I find this somewhat unethical and not something I encourage in my students' essays.

When any one of us begins a new research project, we have first to master the relevant literature. The same rules apply when a scientist or physician decides to write some history. One cannot, I am afraid, write history without first reading history. By reading history, any history, Grove would discover that historians with something worth saying have gone beyond uncritical, non-analytical, and descriptive narratives. There is more to the history of helminthology than is to be found in published research papers.

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NANCY G. SIRAISI. *Medieval & Early Renaissance Medicine: An Introduction to Knowledge and Practice.* 193 pp. Chicago, Ill.: University of Chicago Press, 1990. Price $10.95.

Reviewed by ELEANORA C. GORDON

Nancy Siraisi's survey of late medieval and early Renaissance medicine is a welcome and stimulating history of a vitally important period in the development of medical knowledge — the mid-twelfth through the fifteenth century. Unlike some standard accounts of medieval medicine which are merely litanies of important names and institutions, *Medieval & Early Renaissance Medicine: An Introduction to Knowledge and Practice* describes the orderly evolution of medical knowledge from its roots in ancient medicine, Christianity, and the Muslim world. The fate and transformation of medieval and Renaissance medicine in the sixteenth century and beyond appear in an epilogue. Throughout the book the author shows how the advance of medical knowledge relates to cultural and social influences and to other disciplines.

There are chapters on practitioners and practice, medical education, physiological and anatomical knowledge, disease and treatment, and surgeons and surgery. Although much of the source material comes from Italy, the author's area of expertise, there are frequent references to the rest of western Europe and adequate identification of regional differences.

Siraisi is careful to bring out the variety of practitioners, their education, and their occupation, an aspect not usually stressed in

traditional accounts. We read of learned medical men with university degrees, literate *medici* who were not university trained but nonetheless well-read and competent, and empirics and village healers. Literate practitioners studied such varied texts as ancient authorities, contemporary compendia and new works, and practical texts and abstracts in the vernacular. Practitioners might work for a prince or a merchant, a town, a monastery or be in private practice.

In the chapter on surgeons and surgery the author traces the development of surgery both as a craft and as a body of specialized knowledge. Of particular interest is her discussion of the controversy over wound management. Advocates of the traditional treatment of wounds — healing by secondary intention by the use of salves or corrosive agents — and the iconoclasts who recommended simple cleansing and closure of fresh wounds without tissue damage both based their treatment on the complexion theory. As was common in medieval therapy, Galenic doctrine could be tailored to fit the results of experience.

In her discussion of treatment, Siraisi emphasizes that one aim of medieval therapy was to maintain health according to the Galenic doctrine of balancing the humors. The physician, therefore, advised about diet, prescribed appropriate exercise, drew attention to environmental conditions, and monitored the patient's state of mind. Such a holistic approach is a far cry from the popular view that medieval therapy consisted mostly of arcane compounds of repulsive material.

The numerous illustrations taken from contemporary manuscripts are an important part of the book. The explanatory captions enhance their value and serve as worthwhile additions to the text. The author thoughtfully includes suggestions for further reading and selected primary sources available in English translation. General readers will find *Medieval & Early Renaissance Medicine* enlightening. Students of history, medical history, and history of science will find it an invaluable resource and a stimulus to further study in the field.

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RICHARD A. MECKEL. *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850–1929.* 294 pp. Baltimore, Md.: Johns Hopkins University Press, 1990. Price $42.50.

Reviewed by JANET GOLDEN

In the past decade, historians of American pediatrics have largely turned from questions of the growth and maturation of the specialty and conceptualization of pediatric knowledge to studies of pediatrics as the meeting ground of medicine and social welfare. In addition, there have been several studies assessing the impact of childhood illness and death on individual families and on the society as a whole. These new works reflect the influence of women's history and social history within the historical profession as well as a desire to place in historical context the on-going policy debates about how to reduce the infant mortality rate. Are childhood diseases medical problems or welfare problems, we ask? And do we solve them by instructing pregnant women in good health habits, by providing them with prenatal and postnatal care, or by supplementing their income? These questions, Richard A. Meckel's book, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850–1929,* tells us, have been posed and partially answered, for almost 140 years.

Save the Babies is a rare combination of medical history, social welfare history, and political history. Studying the successive campaigns against infant mortality in the United States between the mid-nineteenth century and the Great Depression, Meckel seeks to explain not their successes and failures, but the reasons why they were begun. Thus he avoids the demographic questions — of whether specific measures from the construction of sewers to the pasteurization of milk had any measurable effects — and endeavors to understand why certain paths to reform were followed, while others were bypassed. He compares, for example, the adoption of mothers' pensions and national health insurance by European nations, with the opposition to federal health care programs in the United States. Such decisions, he concludes, reflected the power of organized and privatized medicine, and also a longstanding reluctance to see health needs in economic terms. As Meckel notes, while British sociomedical investigators divided the populations they studied into socioeconomic classes, "their American counterparts showed more interest in discovering racial and ethnic differentials"

(p. 131). As a result, policies targeted certain groups within the poor, while other groups were largely ignored.

Efforts to save babies, according to Meckel, evolved through several stages beginning with general public health measures designed to improve the urban environment and moving to a more sophisticated program targeted at improving the milk supply. Concurrently, the community of interest expanded to include social welfare leaders and philanthropists as well as public health and medical professionals. This new base of support prepared the way for the Progressive Era campaign to combat infant mortality. Building upon the earlier efforts but encompassing a variety of new programs, the Progressives aimed at educating mothers of all classes. Finally, in the wake of numerous studies of infant mortality, which indicated an increase in neonatal mortality while other deaths in the first year were declining, a new crusade was inaugurated in the 1920s to promote access to medical care during pregnancy and delivery and to pass protective legislation for pregnant women. In a chapter entitled "The Steps Not Taken," Meckel explores why such legislation was not enacted, and in a subsequent chapter why the Sheppard-Towner Act, which funded maternal and infant health education programs, had such a brief life. The triumph of American medical professionalization, Meckel leads us to conclude, was a victory of medical self interest over the national welfare.

In unraveling the complex history of American infant welfare policy, Meckel invites a broad readership. His well researched work should be studied by policy analysts and medical practitioners as well as by historians. Only by understanding the roots of contemporary social problems can we begin to address them.

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JOHN DUFFY. *The Sanitarians: A History of American Public Health*. 316 pp. Champaign, Ill.: University of Illinois Press, 1990. Price $32.50.

Reviewed by STUART GALISHOFF

As John Duffy relates in *The Sanitarians: A History of American Public Health,* before the Civil War, American public health was almost entirely limited to quarantine and sanitation. Moreover,

boards of health only became active when pestilential diseases, such as cholera, yellow fever, and smallpox, threatened to disrupt the life of the community. When the epidemic receded, their powers lapsed and the boards ceased to function.

The success of the New York Metropolitan Board of Health in turning back an invasion of cholera in 1866 and that of the United States Sanitary Commission in safeguarding the health of Union Army soldiers led to the institutionalization of public health. Permanent public health departments were established in the larger cities, and some fledgling state health agencies were organized. Still, public health endeavors during the late-nineteenth century were hampered by political interference, rapid, unplanned urban growth, and lack of scientific knowledge.

Around the turn of the twentieth century, public health was revolutionized by the advent of bacteriology and the germ theory of disease. Vaccines and serums were developed for rabies, diphtheria, and other dread diseases. The control of insect vectors led to the eradication of yellow fever and to a sharp reduction in the incidence of malaria. The filtration of municipal water supplies greatly lowered the incidence of waterborne diseases. But some of the nation's most serious public health problems, notably tuberculosis and infant mortality, had to be addressed in a different manner. Education and the early detection and treatment of illness would become the cornerstones of what was called "the new public health."

Increasingly, the federal government became involved in public health. The Sheppard-Towner Act of 1921 provided an annual appropriation for five years of $1,240,000 for the advancement of maternity and infant welfare. However, it was not until the Great Depression that the national government began to chart the course of public health in the United States. The Social Security Act of 1935 provided millions of dollars for maternal and infant care and other public health services.

Since the end of World War II, many health risks have been identified that are so woven into the social fabric that they cannot be dealt with effectively without new social welfare initiatives. In particular, governments at all levels must become more deeply involved in mitigating the disastrous effects of poverty on health and in reducing environmental hazards. For the most part, health departments have been unwilling to get involved in politically sensi-

tive issues, especially when the American Medical Association has voiced its disapproval.

Duffy's account of the history of American public health depicts dedicated public servants and physicians making slow steady progress against the forces of apathy, ignorance, vested interest, and the traditions of individualism and limited government. I would be more inclined to emphasize the failure to develop strong community health programs, the nation's comparatively high infant mortality rate, and the class and ethnic prejudices that result all too often in the poor receiving second-class health care.

This work fills a yawning gap in the literature. Furthermore, it is comprehensive, well organized, easy to read, and a work of sound scholarship.

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J. GORDON SCANNELL, ed. *Wanderjahr, The Education of a Surgeon: Edward D. Churchill.* 213 pp. Boston, Mass.: Francis A. Countway Library of Medicine, 1990. Price $18.95.

Reviewed by PALMER H. FUTCHER

Surgeons will be fascinated by *Wanderjahr, The Education of a Surgeon: Edward D. Churchill.* Edward D. Churchill (1896–1972) was from 1931 a surgical chief at the Massachusetts General Hospital (M.G.H.) and later president of the American Surgical Association and the American Association for Thoracic Surgery. His essay recounts informally and engagingly an important transition in his specialty and education for it: the extensive replacement by European techniques of the American operating room and physiological laboratory procedures, in which he had been schooled in the early 1920s.

The medium presenting Churchill's thoughtful observations is a transcript of interviews conducted in 1956 by Saul Benison incidental to an oral history program at Columbia University. The focus was Churchill's "strangely unorganized" (p. 28) Moseley Travelling Fellowship awarded for 1926–1927 by his alma mater, Harvard Medical School. Without introduction, the 30-year-old recent M.G.H. house officer was able to visit and make fascinating evaluations of many of the leading European surgeons and preclinical

scientists — in Berlin; Otto Lubarsch, a pathologist, and Otto Warburg's laboratory; in Prague, Anton Ghon, a pathologist; in Zürich, Otto Naegeli, a hematologist and Max Cloetta, a pharmacologist; in Bern, Theodor Kocher's surgical successor Fredrich de Quervain and Leon Ascher, a physiologist; in Basel, the surgeon René Leriche; in Heidelberg, Eugen Enderlen, whose surgical techniques Churchill admired; in Stockholm, Hans Jacobaeus and Einar Key, a surgeon; in Lund, Torsten Thunberg, a physiologist; in Copenhagen, Linar Meulengracht, a hematologist; in Hamburg, Ludolf Brauer, a thoracic surgeon who permitted Churchill to scrub with him, and Wilhelm Bruecker, a surgeon; and in London among others the neurosurgeon and educator Wilfred Trotter and the physiologist Henry Dale.

In addition to these shorter visits, Churchill spent several weeks with the pathologist Max Borst in Munich and the physiologist August Krogh in Copenhagen. From the latter he learned something of the capillary circulation and the related importance of plasma colloid pressure. During his *wanderjahr* he enjoyed quite extensive tramping and skiing in Switzerland and formed an appreciation of the opportunities for thoughtful discussion and contemplation in coffee houses.

It was during his stay in Munich that Churchill observed the surgical techniques of Ernst Sauerbruch, the European leader in thoracic surgery who was largely kept busy performing thoracoplasties for pulmonary tuberculosis. He operated with bare hands and for open chest procedures had substituted positive intratracheal pressure for his airtight cabinet in which were confined both the surgeon and all of the patient but his or her head.

J. Gordon Scannell, an associate of Churchill's, edited this volume, appending accounts of Churchill's activities before and after the *wanderjahr.* Churchill's visit to Sauerbruch and the others prepared him to join Evarts Graham as a pioneer in American chest surgery. In 1928 he performed the first successful pericardiectomy in America for constrictive disease. By 1931 he was Homans Professor of Surgery at the M.G.H. He performed safe lobectomies for bronchiectasis, establishing the bronchopulmonary segment as the surgical unit of the lung. He fostered an awareness of the relation of the nutritional status of the patient to the outcome of surgery. He transformed surgical training at the M.G.H. from an apprenticeship to a "rectangular" (p. 150) residency experience with graded responsibility.

After a stroke in 1953, Churchill died in retirement in 1972. His full dictated memoirs remain unpublished. This little volume lacks an index but includes a 45-page biographical register of sketches on many of Churchill's largely Harvard contemporaries. But Philadelphians will find references to Churchill's important association with Cecil Drinker, a medical graduate of the University of Pennsylvania (p. 17), to that university's offer to Churchill of a research professorship before his *wanderjahr* (p. 25), and to his minimal support of John H. Gibbon at the M.G.H., with the consequence that the latter perfected extracorporeal circulation in Philadelphia (p. 143).

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TIMOTHY C. JACOBSON. *Making Medical Doctors: Science and Medicine at Vanderbilt Since Flexner.* 349 pp. Tuscaloosa, Ala.: University of Alabama Press, 1987. Price $26.95.

Reviewed by JANET A. TIGHE

Timothy Jacobson's history of Vanderbilt Medical School, *Making Medical Doctors: Science and Medicine at Vanderbilt Since Flexner,* is, as the book jacket promises, "not a conventional institutional history." Its unconventional character stems both from the engaging clarity of the writing and from the fact that Jacobson's subject is not so much Vanderbilt, as it is the creation of modern scientific medicine. Readers interested in a detailed history of one of the South's most important medical schools in the years between 1920 and 1980 certainly will not be disappointed. Neither will readers wanting to learn more about a larger and more complex historical process: the struggle that "modern" American medical schools engaged in as they attempted to unite the "healing art" of medicine with the inductive knowledge system of science.

The marriage of medicine and science has always been a difficult one, involving partners who have significantly different purposes, habits, and instincts. Jacobson displays a remarkable insight into the dynamics of this troubled partnership, both at Vanderbilt and in the American medical world generally. Medicine, Jacobson argues, is essentially a utilitarian service-oriented system that has as its main purpose the healing of sick people. Science, on the other hand, is a knowledge-producing discipline whose rules and

procedures are designed for finding "truth" regardless of its utility. As Jacobson points out, science's understanding has not always yielded greater service to the sick, and medicine's service to the sick has on more than one occasion obscured scientific understanding. Jacobson demonstrates how institutions of medical education, such as Vanderbilt, have been shaped and continue to be influenced by this disjuncture between science and service.

While many observers of twentieth-century science and medicine have probed these same issues, few have anchored their investigations so firmly in an evaluation of actual events. The struggle to bring science and medicine together is not an abstract intellectual activity in Jacobson's book. Instead, it is a compelling reality that has affected the lives of generations of Vanderbilt students, faculty, and patients in the form of institutional policies, educational practices, research agendas, patient protocols, and financial plans. What gives Jacobson's book its power is his ability to take the seemingly mundane particulars of life at Vanderbilt and use them to illuminate much broader and more significant questions about the linking of science and medicine.

The author also displays a firm grasp of the contemporary situation facing American medical schools. Jacobson's strong interest in contemporary problems and issues is noteworthy, for it influences directly his interpretation of several key historical developments. In less skillful hands this use of the present as a kind of filter through which to view past events and ideas could lead to dangerous distortions of the historical record. In Jacobson's book there is only one such false note, and that is his failure to explain fully how Vanderbilt was affected by the South's changing social, economic, and political position in the latter part of the twentieth century. In most other instances Jacobson's understanding of the present serves only to enrich his interpretation of the past. This is particularly true in regard to his examination of the career and ideas of medical education giant Abraham Flexner. Jacobson's thoughtful analysis of the financial and educational world Flexner helped create for modern medicine deserves close attention. His provocative argument about American medical education's future in an era he describes as pre-Flexnerian and proprietary is especially intriguing.

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DIANA B. DUTTON. *Worse Than the Disease: Pitfalls of Medical Progress*. 381 pp. Cambridge: Cambridge University Press, 1988. Price $29.95.

Reviewed by WILLIAM G. ROTHSTEIN

Worse Than the Disease: Pitfalls of Medical Progress seeks to demonstrate that "medical and scientific 'advances' can do harm as well as good, and that judgments about both risks and benefits are not automatic or absolute but are made by individuals and agencies acting in the context of particular social, political, and economic pressures" (pp. 350–351). The author, Diana Dutton, also claims that "we who use medicine's innovations, who bear their risks, and who, both as taxpayers and consumers, pay for the products and the research that made them possible, have little if anything to say about the nature and pace of medical progress" (p. 350). Although written in an often polemical style, the book is thoroughly researched and careful about its major conclusions.

The author examines four medical innovations, stressing their implementation rather than their scientific aspects. One is DES, a synthetic estrogen used for decades to help prevent miscarriages, as a post-coital contraceptive, and as animal food. Although its carcinogenic properties were known almost immediately, the drug remained in regular use until rare cancers and other medical problems were discovered in young women whose mothers had used the drug during pregnancy. The book describes the roles of the pharmaceutical firms and the Food and Drug Administration.

The second case study concerns the long-floundering federally sponsored program to construct an artificial heart. There is a detailed description of the early artificial heart implants, in which "therapy" was used to justify the most callous and crude medical experimentation and the crassest commercialization, with appalling consequences for the patients.

The third case study examines the swine flu immunization program of 1976, in which a program to immunize the entire population was started based on dubious and sometimes inconceivable assumptions and continued despite growing evidence that it was a mistake.

The last case study is an overview of the major issues involved in genetic engineering.

In all four innovations both public officials and scientists "tended to be overly optimistic about their ability to overcome

scientific or technical obstacles," "to underestimate and undervalue the likelihood and seriousness of possible problems, especially those that were difficult to quantify" (p. 351), to be oblivious to issues of cost effectiveness, and to make glib judgments on subjects outside their expertise. The federal health bureaucracy frequently equivocated when confronted with questions involving the rights and safety of patients and the public.

The remainder of the book examines risks and patient rights, victim compensation, the "prevailing orientation toward high-cost, high-technology medicine" (p. 313), and public participation in decision making. Although these chapters make many important points, they are less well researched than the case studies and are frequently simplistic and repetitive. The author too often believes that all medical innovations are expensive and benefit few people, that public involvement can be equated with the actions of self-styled public interest groups, and that innovations still in the realm of fantasy are the issues of greatest concern.

Overall, this is a probing and constructive book that can be unhesitatingly recommended to interested readers and teachers, who can use individual chapters in the classroom. Those of us who prefer a more dispassionate analysis must realize that disinterested observers do not write these kinds of books, upon which the integrity of science ultimately depends.

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MALCOLM G. TAYLOR. *Insuring National Health Care: The Canadian Experience.* 229 pp. Chapel Hill, N.C.: University of North Carolina Press, 1991. Price $29.95.

Reviewed by RAISA B. DEBER

As dissatisfaction with the U.S. health care system rises, Americans have again looked north to see what, if anything, can be learned from Canada. Medicare, as Canada terms its programs of universal and comprehensive insurance for medical and hospital care without any direct charges to patients, is Canada's most popular social program, sharing the same "sacred cow" status as Social Security has enjoyed in the United States. Malcolm Taylor's *Insuring National*

Health Care: The Canadian Experience is accordingly subtitled "What Americans can learn from one of the most successful health care programs in the world."

The book is divided into three sections. Its middle is an abridgment and revision of *Health Insurance and Canadian Public Policy,* Taylor's classic account of the origins of Canada's health care system; he refers readers interested in a fuller account of the story to the original. The retained material now forms the innards of a sandwich purportedly packaged for a non-Canadian market. Section One is composed of two chapters describing Canada's political process and health care system. Section Three contains speculations on future directions, concentrating on "cost containment, the aging of the population, the impending surplus of physicians, the shifting emphasis from sickness care to wellness, and the possibility of introducing innovations in the health services delivery system" (p. 187).

Malcolm Taylor was a participant observer for many of the events he described, and writes knowledgeably and with insight. The book is good enough to make one wish he had had better editorial support. Although rarely inaccurate, the writing is often incomplete, and thereby potentially misleading on key details, particularly for non-expert readers. The book leaps between lucid commentaries and overly detailed and confusing abbreviations of marginally relevant facts; one example is the insertion of several dated accounts of the political fortunes of provincial political parties into Chapter One's excellent account of Canada's political system and its implications for health policy. The discussion also did not foresee the current threats to the survival of Canada; the current constitutional and economic crises may imperil even as beloved a program as Medicare, although it is likely to be the last program cast over the side of the sinking ship of state. (Indeed, Canada's social democratic opposition parties have recently suggested "preserving universal Medicare" by inserting the "right to health care" into Canada's constitution!)

The book still gives a first-rate description of the events leading up to Canadian Medicare. It is less valuable at pointing lessons for the United States, except very indirectly. Data is rarely placed in comparative perspective, and the brief concluding discussions of system problems are not really placed into international context.

Since America is the land of hype, it seems ungracious to object to exaggerated claims on this book's cover. No, this book does not really tell Americans what they can learn from Canada. But it does

present a lucid account of an interesting historical period, accompanied by some insightful speculations about the future, and as such can be highly recommended.

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Book Reviewers In This Issue

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Book List

New Books In the History of Medicine in the Historical Collections of the Library, January to June 1991

JACK ECKERT

Karel B. Absolon, *Developmental Technology of Gastric Surgery-Vagotomy, 1521 to Present,* second edition (Rockville, Md.: Kabel Publishers, 1987).

Lee Anderson, *Iowa Pharmacy, 1880–1905: an Experiment in Professionalism* (Iowa City, Iowa: University of Iowa Press, 1989).

Alfred Blalock, *Principles of Surgical Care: Shock and Other Problems* (St. Louis, Mo.: C. V. Mosby Company, 1940).

Robert E. Carlson, compiler and editor, *Delaware County (Pennsylvania) Bibliography* (Kennett Square, Pa.: KNA Press, 1989).

Roger Cooter, *Phrenology in the British Isles: an Annotated, Historical Biobibliography and Index* (Metuchen, N.J. and London: Scarecrow Press, 1989).

David Courtwright, Herman Joseph, and Don Des Jarlais, *Addicts Who Survived: an Oral History of Narcotic Use in America, 1923–1965* (Knoxville, Tenn.: University of Tennessee Press, 1989).

Albert E. Cowdrey, *The Medics' War* (Washington, D.C.: Center for Military History, United States Army, 1987).

Javier DeFelipe and Edward G. Jones, *Cajal on the Cerebral Cortex: an Annotated Translation of the Complete Writings* (New York and Oxford: Oxford University Press, 1988).

Alan Derickson, *Workers' Health, Workers' Democracy: the Western Miners' Struggle, 1891–1925* (Ithaca and London: Cornell University Press, 1988).

Linda Donn, *Freud and Jung: Years of Friendship, Years of Loss* (New York: Collier Books, 1988).

Jack D. Ellis, *The Physician-Legislators of France: Medicine and Politics in the Early Third Republic, 1870–1914* (Cambridge and New York: Cambridge University Press, 1990).

J. Worth Estes, *The Medical Skills of Ancient Egypt* (Canton, Mass.: Science History Publications, 1989).

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William S. Fields and Noreen A. Lemak, *A History of Stroke: Its Recognition and Treatment* (New York and Oxford: Oxford University Press, 1989).

Roger French and Andrew Wear, editors, *The Medical Revolution of the Seventeenth Century* (Cambridge: Cambridge University Press, 1989).

Robert C. Fuller, *Alternative Medicine and American Religious Life* (New York and Oxford: Oxford University Press, 1989).

Mirko D. Grmek, *Histoire du Sida: Début et Origine d'une Pandémie Actuelle* (Paris: Médecine et Sociétés Payot, 1989).

Ove Hagelin, compiler, *Rare and Important Medical Books in the Library of the Swedish Society of Medicine: a Descriptive and Annotated Catalogue* (Stockholm, Sweden: Svenska Lakaresallskapet, 1989).

Geoffrey Harding, *Opiate Addiction, Morality, and Medicine: from Moral Illness to Pathological Disease* (New York: St. Martin's Press, 1988).

James E. Harris and Edward F. Wente, editors, *An X-Ray Atlas of the Royal Mummies* (Chicago and London: University of Chicago Press, 1980).

Darlene Clark Hine, *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890–1950* (Bloomington and Indianapolis: Indiana University Press, 1989).

Julius Hirschberg, *The History of Ophthalmology, Volume 9: the First and Second Half of the Nineteenth Century,* trans. Frederick C. Blodi (Bonn, Germany: J. P. Wayenborgh Verlag, 1990).

Robert R. Holt, *Freud Reappraised: a Fresh Look at Psychoanalytic Theory* (New York and London: Guilford Press, 1989).

Margo Horn, *Before It's Too Late: the Child Guidance Movement in the United States, 1922–1945* (Philadelphia, Pa.: Temple University Press, 1989).

W. W. Keen James, editor, *The Memoirs of William Williams Keen, M.D.* (Doylestown, Pa.: W. W. Keen James, 1990).

Ludmilla Jordanova, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries* (Madison, Wis.: University of Wisconsin Press, 1989).

R. H. Kampmeier, *Vanderbilt University School of Medicine: the Story in Pictures from its Beginning to 1963* (Nashville, Tenn.: Vanderbilt University Medical Center, 1990).

David LeVay, *The History of Orthopaedics: an Account of the Study and Practice of Orthopaedics from the Earliest Times to the Modern Era* (Park Ridge, N.J.: Parthenon Publishing Group, 1990).

Bengt Ljunggren, *Great Men with Sick Brains & Other Essays* (Park Ridge, Ill.: American Association of Neurological Surgeons, 1990).

Diana Elizabeth Long and Janet Golden, editors, *The American General Hospital: Communities and Social Contexts* (Ithaca and London: Cornell University Press, 1989).

Mary Kilbourne Matossian, *Poisons of the Past: Molds, Epidemics, and History* (New Haven and London: Yale University Press, 1989).

Katherine Mandusic McDonell, editor, *The Journals of William A. Lindsay: an Ordinary Nineteenth-Century Physician's Surgical Cases* (Indianapolis, Ind.: Indiana Historical Society, 1989).

Thomas McKeown, *The Origins of Human Disease* (Oxford and New York: Basil Blackwell, 1988).

Richard A. Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850–1929* (Baltimore and London: Johns Hopkins University Press, 1990).

S. A. J. Moorat, *Catalogue of Western Manuscripts on Medicine and Science in the Wellcome Historical Medical Library, Vol. II: MSS. Written after 1650 A.D.* (London: Wellcome Institute of the History of Medicine, 1973).

Frank Mort, *Dangerous Sexualities: Medico-moral Politics in England Since 1830* (London and New York: Routledge and Kegan Paul, 1987).

Ornella Moscucci, *The Science of Woman: Gynaecology and Gender in England, 1800–1929* (Cambridge and New York: Cambridge University Press, 1990).

Fitzhugh Mullan, *Plagues and Politics: the Story of the United States Public Health Service* (New York: Basic Books, 1989).

Vivian Nutton, editor, *Medicine at the Courts of Europe, 1500–1837* (London and New York: Routledge, 1990).

James S. Olson, compiler, *The History of Cancer: an Annotated Bibliography* (New York, Westport, Conn., and London: Greenwood Press, 1989).

Ambrose Paré, *Ten Books of Surgery with the Magazine of the Instruments Necessary for It,* trans. Robert White Linker and

Nathan Womack (Athens, Ga.: University of Georgia Press, 1969).

Roy Porter, *Health for Sale: Quackery in England, 1660–1850* (Manchester and New York: Manchester University Press, 1989).

James C. Riley, *Sickness, Recovery, and Death: a History and Forecast of Ill Health* (Iowa City, Iowa: University of Iowa Press, 1989).

Vivian Ovelton Sammons, *Blacks in Science and Medicine* (New York: Hemisphere Publishing, 1990).

Francis O. Schmitt, *The Never-Ceasing Search* (Philadelphia, Pa.: American Philosophical Society, 1990).

Susan E. Searing, editor, *The History of Women and Science, Health, and Technology: a Bibliographic Guide to the Professions and the Disciplines* (Madison, Wis.: University of Wisconsin System Women's Studies Librarian, 1988).

John F. Sena, *The Best-Natured Man: Sir Samuel Garth, Physician and Poet* (New York: AMS Press, 1986).

Arthur M. Silverstein, *A History of Immunology* (San Diego, Ca.: Academic Press, 1989).

Nancy G. Siraisi, *Medieval & Early Renaissance Medicine: an Introduction to Knowledge and Practice* (Chicago and London: University of Chicago Press, 1990).

Jake W. Spidle, Jr., *The Lovelace Medical Center: Pioneer in American Health Care* (Albuquerque, N. Mex.: University of New Mexico Press, 1987).

Stephen Trombley, *Sir Frederick Treves, the Extra-Ordinary Edwardian* (London and New York: Routledge, 1989).

Heinrich Von Staden, *Herophilus: the Art of Medicine in Early Alexandria* (Cambridge: Cambridge University Press, 1989).

Correspondence

[The following letter was received in response to the article "Wax Models in Dermatology," by Lawrence Charles Parish, et al., which appeared in the March 1991 number of *Transactions & Studies of the College of Physicians of Philadelphia*. Dr. Amadio, of the Department of Orthopedics, Mayo Clinic, Rochester, Minnesota, is an Associate Fellow of the College of Physicians of Philadelphia.]

Dear Dr. Hannaway:

I am writing in regard to the article "Wax Models in Dermatology," by Lawrence Charles Parish, et al., which appeared in *Transactions & Studies of the College of Physicians of Philadelphia*, 1991, *13*:29–74. This fascinating article reviews the use of wax models in general and goes into specific detail on their use in dermatology. I would like to take this opportunity to add further information on the wax model collection of the Mayo Clinic. The only comment regarding Mayo in the text was a reference that wax models had been made there at one time but that production had ceased. Mayo, at one time, had a collection of over three thousand wax models. Unfortunately, due to limitations of space and the vagaries of time, some models were destroyed; but roughly 2,200 remain, of which many represent dermatological subjects. At present, the models are filed according to their area of anatomy and are cataloged on laser disk for easy retrieval. A number of models are on display in Mayo's Patient Education Center. Many other models are used throughout the Mayo Foundation for teaching purposes. Although it is true that Mayo no longer has the three full-time wax sculptors that worked there from the 1930s through the 1960s, there is still one wax sculptor employed at Mayo. As one can imagine, given the explosion in visual communication technology and the high cost of model creation, the current volume of three-dimensional model production is not great, but models are still made.

I do not intend for this letter to detract in any way from the excellent and informative article authored by Parish, et al. However, I do think that it is worthwhile to point out to readers of the *Transactions & Studies of the College of Physicians of Philadelphia* that an additional, large wax model resource, which covers a wide range of medical conditions, does exist in the United States. Based on the tallies presented by Parish, et al., this collection may be the largest outside Europe and certainly one of the largest still extant in the world.

Sincerely,

Peter C. Amadio, M.D.
10 May 1991

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Book references should include the facts of publication [author, *complete title* (place: publisher, date)]. Periodical references should include the year, volume number, and page numbers. The first time a work is referred to in the notes it should be cited in full. Subsequent citations should be by surname of the author and a shortened but unambiguous form of the title, consistently adhered to. "Ibid.," referring to the work named in the immediately preceding reference, may be used when it is unambiguous and effects a real saving of space.

EXAMPLES

William H. Helfand, *Medicine and Pharmacy in American Political Prints* (Madison, Wis.: American Institute of the History of Pharmacy, 1967), p. 35.

Helfand, *Medicine and Pharmacy*, p. 51.

Ibid., p. 60.

Wendy Shadwell, "Britannia in Distress," *American Book Collector*, 1986, 7:1.

A complete set of instructions will be sent, upon request, to authors.

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